Tahoe Forest Hospital District

2017-06-22 Regular Meeting of the Board of Directors

Thursday, June 22, 2017 at 4:00 p.m.

Tahoe Truckee Unified School District (TTUSD)

11603 Donner Pass Road, Truckee, CA 96161

Meeting Book - 2017-06-22 Regular Meeting of the Board of Directors

6/22/17 Agenda

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15.1. Approval of Meeting Minutes

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16. ITEMS FOR BOARD ACTION

16.1. Election of Board Vice President

No related items.

16.2. CEO Employment Agreement Amendment

No related materials at this time. Amendment will be distributed at meeting pending closed session item.

16.3. Tahoe Forest Healthcare Services Board Member Appointment

CEO

Verbal presentation.

16.4. Policy Review

16.4.1.a. ABD-21 Physician and Professional Service Agreements REDLINE 2017_0616.pdf — Page 190

16.4.1.b. ABD-21 Physician and Professional Service Agreements CLEAN 2017_0616.pdf — Page 203

17. ITEMS FOR BOARD DISCUSSION

17.1. Master Planning Presentation.pdf — Page 212

17.2. Board Education

17.2.1. Legislative Update

Ted Owens

No related materials.

17.3. CEO Incentive Compensation Criteria

Materials to be distributed during presentation.

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

19. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

19.1. 2017-06-14 Governance Committee_FINAL Agenda.pdf Page 222

19.2. 2017-06-20 Board Finance Committee_Agenda.pdf Page 223

ITEMS 20 - 25: See Agenda

26. ADJOURN

REGULAR MEETING OF THE BOARD OF DIRECTORS

AGENDA

Thursday, June 22, 2017 at 4:00 p.m.
Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT AUDIENCE**
This is an opportunity for members of the public to comment on any closed session item appearing before the Board on this agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Clerk of the Board 24 hours prior to the meeting to allow for distribution.

5. **BOARD MEMBER APPOINTMENT**
An oath of office will be administered to the newly appointed Board Member.

6. **CLOSED SESSION**

6.1. Hearing (Health & Safety Code § 32155)
Subject Matter: Corporate Compliance Report – Closed Session
Number of items: One (1)

6.2. Liability Claims (Gov. Code § 54956.95) ◈
Claimant: Deb Baldwin

6.3. Conference with Labor Negotiator (Gov. Code § 54957.6)
Name of Negotiator to Attend Closed Session: Charles Zipkin, M.D.
Unrepresented Employee: Chief Executive Officer

6.4. Approval of Closed Session Minutes ◈
05/25/2017

6.5. TIMED ITEM – 5:30PM – Hearing (Health & Safety Code § 32155) ◈
Subject Matter: Medical Staff Credentials

7. **DINNER BREAK**

APPROXIMATELY 6:00 P.M.

8. **OPEN SESSION – CALL TO ORDER**

9. **REPORT OF ACTIONS TAKEN IN CLOSED SESSION**

◈ Denotes Action Item

10. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

11. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

12. INPUT FROM EMPLOYEE ASSOCIATIONS

This is an opportunity for members of the Employee Associations to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes.

13. ACKNOWLEDGMENTS

13.1. June 2017 Employee of the Month....................ATTACHMENT

14. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

14.1. Medical Executive Committee (MEC) Meeting Consent Agenda ....ATTACHMENT

MEC recommends the following for approval by the Board of Directors: proposed amendments to Medical Staff Bylaws, Annual Clinical Policy and Procedure Approvals for Diagnostic Imaging/Radiation Safety Policies and Procedures and 2017 Emergency Operations plan.

15. CONSENT CALENDAR ◈

These items are expected to be routine and non-controversial. They will be acted upon by the Board without discussion. Any Board Member, staff member or interested party may request an item to be removed from the Consent Calendar for discussion prior to voting on the Consent Calendar.

15.1. Approval of Minutes of Meetings

5/25/2017....................ATTACHMENT

15.2. Financial Report

15.2.1. Financial Report- May 2017 ....ATTACHMENT

15.3. Contracts

15.3.1. John Hortareas, D.O. – Hospitalist Services Agreement....................ATTACHMENT

15.3.2. Gerald Schaffer, M.D. – Professional Services Agreement – Multi-Specialty Clinic....ATTACHMENT

15.3.3. Chelsea Wicks, M.D. – Professional Services Agreement – Multi-Specialty Clinic......ATTACHMENT

15.3.4. Sierra Nevada Oncology – Professional Services Agreement....................ATTACHMENT

15.3.5. Kevin Cahill – Call Coverage Agreement ....ATTACHMENT

15.3.6. Joseph Logan Norris – Independent Contractor Agreement....................ATTACHMENT

15.4. Staff Reports (Information Only)

15.4.1. CEO Board Report ....ATTACHMENT

15.4.2. COO Board Report....................ATTACHMENT

15.4.3. CNO Board Report....................ATTACHMENT

15.4.4. CIO Board Report ....ATTACHMENT

15.4.5. CMO Board Report....................ATTACHMENT

16. ITEMS FOR BOARD ACTION ◈

16.1. Election of Board Vice President

The Board of Directors will elect a new Vice President to replace the current vacancy.

16.2. Tahoe Forest Healthcare Services Board Member Appointment
The Board of Director will consider for approval a new board member for Tahoe Forest Healthcare Services.

16.3. Chief Executive Officer Employment Agreement ....ATTACHMENT*
The Board of Directors will review and consider for approval an amendment to the CEO's Employment Agreement.

16.4. Policy Review

16.4.1. ABD-21 Physician and Professional Service Agreements ....ATTACHMENT
The Board of Directors will review and consider for approval revisions on policy ABD-21 Physician and Professional Service Agreements.

17. ITEMS FOR BOARD DISCUSSION

17.1. Master Planning .... ATTACHMENT
The Board of Directors will receive a presentation on the District's master planning efforts.

17.2. Board Education

17.2.1. Legislative Update
Ted Owens, TFHD Executive Director of Governance and Community Development, will educate the Board of Directors on proposed legislation changes at the State and Federal level.

17.3. CEO Incentive Compensation .... ATTACHMENT*
The Board of Directors will discuss CEO Incentive Compensation Criteria.

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

19. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

19.1. Governance Committee Meeting – 06/14/2017 .... ATTACHMENT
19.2. Finance Committee Meeting – 06/20/2017 ....ATTACHMENT
19.3. Personnel Committee Meeting – No meeting held in June.
19.4. Quality Committee Meeting – No meeting held in June.
19.5. Community Benefit Committee Meeting – No meeting held in June.

20. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

21. ITEMS FOR NEXT MEETING

22. BOARD MEMBERS REPORTS/CLOSING REMARKS

23. CLOSED SESSION CONTINUED, IF NECESSARY

24. OPEN SESSION

25. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY

26. ADJOURN

◈ Denotes Action Item

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is July 27, 2017 at 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

Employee of the Month, June 2017
Christine Smigel, Customer Care Navigator-CHSP

We are honored to announce Christine Smigel, Customer Care Navigator, CHSP as our June Employee of the Month. Christine is an exemplary employee who comes to work every day with a smile on her face and a “can do” attitude. Her smile radiates and has a way of making people around her smile.

Christine readily embraces new projects and willingly takes ownership above and beyond what is expected. The Center is in the process of launching a new community education program for prediabetes called Prevent T2. Christine has increased her knowledge of diabetes and is able to speak confidently with the public about the program.

Christine demonstrates quality as she pours her heart into her work with the highest personal integrity in getting the job done right every time.

Christine is very understanding in ALL the work she does. She cares deeply about how other people. While she was making phone calls for the program promotion (nearly 130 phone calls all by herself!!), she always came back to the program coordinator with edits to the "script" that would make the recipients of the calls feel more comfortable.

She has shown Excellence by taking specific notes on every person she spoke with. She truly cared about the people she spoke with and wanted to make sure all information shared with me was accurate.

She shows stewardship daily in all of her duties by helping community members get connected with the resources that will fit their needs the best, even if the best thing for the participant is not the initial one she had in mind prior to talking with them. She has even gone to the senior center and talked individually with low income seniors to promote our program and help them find ways to participate, even if they couldn't afford the price we set.

Lastly, Christine exhibits the BEST teamwork in every work interaction. She cares about her coworkers' concerns and tries to find solutions to any issues that come up.

Christine meets and exceeds the definition of the TFHS mission and values but most of all is an inspiration and a model of quality care for our Health System.

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MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO THE BOARD OF DIRECTORS
Thursday, June 22, 2017

Executive Committee	The Executive Committee recommends approval of the following: On February 2, 2017, the Bylaws Committee met and conducted its annual review of the Medical Staff Bylaws, Rules and Regulations. Legal counsel reviewed and approved the proposed amendments and on March 16, 2017 the Medical Executive Committee recommended amendments to the voting members of the Active Medical Staff. As per Article 14.2 of the Medical Staff Bylaws, an affirmative vote was received by two thirds (2/3) of the staff members voting on the proposed amendments. The amendments are now provided to the Board of Directors for their consideration and approval. Please see the attached red-lined versions of the Bylaws, and Rules and Regulations. Changes may be found under the following referenced articles in the Bylaws and Rules and Regulations: <u>BYLAWS</u>: • DEFINITIONS • ARTICLE 4.2-6 SIGNIFICANT MISREPRESENTATION OR OMISSIONS • ARTICLE 5.4-1 TEMPORARY CLINICAL PRIVILEGES • ARTICLE 5.4-2 (B) TEMPORARY CLINICAL PRIVILEGES • ARTICLE 8.2-5 OFFICERS OF THE MEDICAL STAFF • ARTICLE 9.5-1 QUALIFICATIONS OF DEPARTMENT CHAIR • ARTICLE 9.5-2 SELECTION OF DEPARTMENT CHAIR • ARTICLE 10.3-1 MEDICAL EXECUTIVE COMMITTEE • ARTICLE 11.1-1 ANNUAL MEETING • ARTICLE 11.1-2 REGULAR GENERAL MEDICAL STAFF MEETINGS • ARTICLE 11.6-1 ATTENDANCE REQUIREMENTS • ARTICLE 13.2 DUES OR ASSESSMENTS		Recommend approval

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MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO THE BOARD OF DIRECTORS
Thursday, June 22, 2017

	RULES AND REGULATIONS: • RULES AND REGULATIONS: 2.1-1 ETHICS COMMITTEE • RULES AND REGULATIONS: 2.3-1 QUALITY ASSESSMENT CO. • RULES AND REGULATIONS: 2.4-1 INTERDISCIPLINARY PRACTICE (IDPC) • RULES AND REGULATIONS: 2.4-2 IDPC • RULES AND REGULATIONS: 2.4-3 IDPC		
	Annual review and approval of policies and procedures. All individual policies have been brought to department meetings for approval. The Table of Contents of these policies are for annual approval:		
1. Quality Assessment Committee	Annual Clinical Policy and Procedure Approvals: • Diagnostic Imaging/Radiation Safety Policies and Procedures • 2017 Emergency Operations Plan		Recommend approval

TAHOE FOREST HOSPITAL (CAH)
INCLINE VILLAGE COMMUNITY HOSPITAL (CAH)

MEDICAL STAFF BYLAWS

2016

1197911.2 Approved by MEC 1/20/16, 7/21/16; by BOD 1/28/16; 9/22/16

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TAHOE FOREST HOSPITAL DISTRICT MEDICAL STAFF BYLAWS

PREAMBLE

These Bylaws are adopted In recognition of the mutual accountability, interdependence, and responsibility of the Medical Staff and the Board of Directors of Tahoe Forest Hospital District which include Tahoe Forest Hospital and Incline Village Community Hospital; both are Critical Access Hospitals in protecting the quality of medical care provided in the Hospital and assuring the competency of the Hospital's Medical Staff. The Bylaws provide a framework for self government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, including but not limited to structuring itself to provide a uniform standard of quality patient care, treatment and services; 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 to oversee and manage 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 revoking Medical Staff officers; and address the respective rights and responsibilities of the Medical Staff and the Board of Directors.

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 the Hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Board of Directors commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Board of Directors will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

Each member of the Medical Staff shall abide by the Medical Staff Bylaws and Rules and lawful standards and policies of the Medical Staff and the Hospital, including, but not limited to, any applicable Medical Staff and/or Hospital policies respecting unlawful harassment and Practitioner conduct.

DEFINITIONS

1. HOSPITAL means Tahoe Forest Hospital and Incline Village Community Hospital.

2. BOARD OF DIRECTORS means the Board of Directors of the Hospital, and may include a committee or individual authorized by the Board of Directors to act on its behalf.

3. CHIEF EXECUTIVE OFFICER means that individual appointed as Chief Executive Officer of the Hospital by the Board of Directors to act on its behalf in the overall management of the Hospital.

4. MEDICAL STAFF or STAFF means those physicians (M.D. or D.O.), dentists, and podiatrists who have been appointed to the Medical Staff pursuant to the terms of these Bylaws.

5. MEDICAL EXECUTIVE COMMITTEE means the Medical Executive Committee of the Medical Staff.

6. PHYSICIAN means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

7. DENTIST means an individual with a D.D.S. or D.M.D. degree who is currently licensed to practice dentistry. It shall include oral surgeons.

8. PODIATRIST means an individual with a D.P.M. degree who is currently licensed to practice podiatric medicine.

9. PRACTITIONER means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist, or Allied Health Professional holding a current license to practice who may or may not be a member of the Medical Staff.

10. MEMBER means a practitioner who is a member of the Medical Staff.

11. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to Medical Staff members ~~or allied health professionals~~ to provide patient care and includes unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges~~within the facilities of the Hospital~~.

12. MEDICAL STAFF YEAR means the period from January 1 through December 31.

13. CHIEF OF STAFF means the chief officer of the Medical Staff selected pursuant to these Bylaws.

14. AUTHORIZED REPRESENTATIVE or Hospital's Authorized Representative means the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

15. EMERGENCIES are defined as "an acute life threatening situation or acute sensory or limb threatening situation".

16. URGENT CASES are defined as "sub-acute situations where undue delay will produce Irreversible damage".

17. TELEMEDICINE is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

18. INELIGIBLE PERSON means any person who is currently excluded, suspended, debarred, or ineligible to participate in any federal health care program, or has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

ARTICLE I

NAME

The name of this organization is the Medical Staff of Tahoe Forest Hospital District.

ARTICLE II

MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No physician, dentist, or podiatrist, including those in a medical-administrative position by virtue of an agreement with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he/she is a member of the Medical Staff enjoying corresponding privileges or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws and the Rules. Appointment to the Medical Staff shall confer only those privileges and prerogatives, which have been granted in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

A practitioner must demonstrate compliance with all the basic standards set forth in this section in order to qualify for Medical Staff membership. To meet the basic qualifications for membership, all applicants must:

a. Demonstrate and maintain their experience, ability (including mental and physical fitness, with or without reasonable accommodations, to perform the functions associated with requested privileges), and current competence to exercise the privileges they wish to hold. These general standards shall require proficiency in all of the following areas:

   1) Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and/or injury, and care at the end of life, as applicable to their specialties.

   2) Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences,

and the application of their knowledge to patient care and the education of others.

3) Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.

4) Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the health care team.

5) Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.

6) Systems-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

b. Document their current licensure as required by law.

c. Demonstrate that they are willing to participate in and properly discharge those responsibilities determined according to these Bylaws;

d. Not be ineligible to participate in federally-funded health care programs, and not become ineligible during any term of membership;

e. Provide ongoing verification of medical malpractice insurance coverage meeting the requirements of these Bylaws in the amount of $1,000,000 and $3,000,000; and

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.

2.2-2 PARTICULAR QUALIFICATIONS

a. Physicians: An applicant for physician membership in the Medical Staff must hold a valid license to practice medicine issued by the Medical Board or Board of Osteopathic Examiners in (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

b. Dentists, Oral Surgeons, and Podiatrists

(1) Dentists and Oral Surgeons: An applicant for dental membership in the Medical Staff must hold a valid license to practice dentistry issued by the Board of Dental Examiners (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for

those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

(2) Podiatrists: An applicant for podiatric membership on the Medical Staff must hold a valid license to practice podiatry issued by the appropriate licensing board (1) the State of California (for those applicants who will be practicing only at the hospital's California facilities); (2) the State of Nevada (for those applicants who will be practicing only at the hospital's Nevada facilities); or (3) both (for those applicants who will be practicing at the hospital's California and Nevada facilities).

2.3 EFFECT OF OTHER AFFILIATIONS

(a) No person shall be entitled to membership in the Medical Staff, assignment to a particular staff category, or the granting or renewal of particular clinical privileges merely because that person:

(1) holds a certain degree;
(2) is licensed to practice in California, Nevada, or any other state;
(3) is a member of any particular professional organization;
(4) is certified by any particular specialty board;
(5) had, or presently has, membership or privileges at this or any other health care facility; or
(6) requires a hospital affiliation in order to participate on health plan provider panels, to obtain or maintain malpractice insurance coverage, or to pursue other personal or professional business interests unrelated to the treatment of patients at this facility and the furtherance of this facility's programs and services.

(b) A revocation, suspension, restriction, or other disciplinary or corrective action by any state licensing authority, professional organization, certification board or health care facility regarding a practitioner's license, certificate, membership or clinical privileges, whether contested or voluntarily accepted, shall constitute grounds for an unfavorable credentialing or peer review action by this Medical Staff. The Medical Staff shall consider the nature and gravity of the charges or allegations and the resulting disciplinary or corrective action, but shall not be obligated to conduct evidentiary proceedings regarding events that occurred elsewhere.

2.4 NON-DISCRIMINATION

No aspect of Medical Staff membership or clinical privileges shall be determined on the basis of color, national origin, gender, religion or creed, marital status, age, sexual preference, or disability including AIDS and related conditions.

2.5 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

(a) A practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a member of the Medical Staff.

(b) A practitioner contracting with the Hospital in an administrative capacity with clinical duties or privileges must be a member of the Medical Staff, achieving his/her status by the normal application and appointment procedures described in these Bylaws.

(c) Unless a contract or agreement executed after the adoption of this provision provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the fair hearing procedures of Article VII of these Bylaws, upon termination or expiration of such practitioner's contract or agreement with the Hospital. Furthermore, if the practitioner's privileges are limited to those subject to the exclusive or semi-exclusive arrangement, Medical Staff membership shall also terminate without the right of access to the fair hearing procedures of Article VII of these Bylaws.

(d) Contracts between practitioners and the Hospital shall prevail over these Bylaws; except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the National Practitioner Data Bank.

(e) Practitioners who subcontract with practitioners who contract with the Hospital will automatically forfeit (without the right of access to the fair hearing procedures of Article VII of these Bylaws) any privileges that are subject to an exclusive or semi-exclusive arrangement if their relationship with the contracting practitioner is terminated. Furthermore, if the practitioner's privileges are limited to those subject to the exclusive or semi-exclusive arrangement, Medical Staff membership shall also terminate without the right of access to the fair hearing procedures of Article VII of these Bylaws. The Hospital may enforce such automatic termination even if the subcontractor's agreement fails to specifically recognize this right.

2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The responsibilities of each member of the Medical Staff and of any practitioner holding temporary clinical privileges are to:

(a) provide patients with the high quality of care, which meets the professional standards of the Medical Staff and the Hospital;

(b) abide by the Medical Staff Bylaws, Medical Staff Rules, Medical Staff and Departmental policies, and Hospital policies that relate to patient care and safety;

(c) discharge in a responsible and cooperative manner, those responsibilities which are assigned by virtue of Medical Staff membership, category, assignment, election, or otherwise, including committee assignments and other credentialing, peer review, and quality assessment and performance improvement duties;

(d) prepare and complete in timely fashion medical and other required records for all the patients to whom the member provides care in the Hospital;

(e) abide by the ethical principles of the appropriate state medical or other professional association(s), and, as applicable, the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association, the Code of

Ethics of the American Osteopathic Association, and the Code of Ethics of the American Podiatry Association;

(f) work with and relate to other staff members, members of other health disciplines, Hospital management and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner so as to create and maintain a working environment conducive to quality and efficient patient care;

(g) make appropriate arrangements for coverage for his/her patients as determined by the Medical Staff, refrain from delegating the responsibility for diagnosis or care of hospitalized patients to any practitioner who lacks the qualifications or privileges to undertake this responsibility, and seek appropriate consultations when indicated;

(h) refuse to engage in division of fees, under any guise whatsoever, or any other improper inducements for patient referral;

(i) participate in continuing education programs;

(j) upon request, provide information from his/her office records as necessary to facilitate the care of or review of the care of specific patients;

(k) participate in such emergency service coverage or consultant panels as may be established by appropriate committees and officials of the Medical Staff;

(l) discharge such other obligations as may be lawfully established from time to time;

(m) notify the Department chairperson or the Chief of Staff in the event the member or practitioner develops a physical, mental, or emotional disability that would significantly interfere with his/her medical practice;

(n) continuously meet the qualifications for membership as set forth in these Bylaws. (It is understood that a member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws and the Rules whenever the Medical Executive Committee has good cause to question whether the member continues to meet such requirement);

(o) protect and preserve the confidentiality of patient health or payment information, including compliance with applicable confidentiality laws and with the confidentiality policies and rules of the Hospital and Medical Staff concerning the use and disclosure of patient health information and records;

(p) provide the Medical Staff Office with a complete and current mailing address and accept Certified or Registered Mail from the Medical Staff;

(q) promptly notify the Medical Staff Office in writing of:

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

(7) any other action that could affect his/her Medical Staff standing and/or clinical privileges at the Hospital.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Courtesy and Honorary. At each time of reappointment, the member's Medical Staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The Active Staff shall consist of members who:

a. meet the general qualifications for membership set forth in Section 2.2 of the Bylaws;

b. have satisfactorily completed the provisional requirements for new staff as described in Section 4.7;

   (1) Until completion of such requirements, they shall be referred to as Provisional Active. References in these bylaws to "Active Staff" shall not be deemed to include members of the Provisional Active Staff unless the intent to include Provisional members is clear.

c. have primary offices and residences in the Truckee/Incline Village area which are located closely enough to the hospital to allow for appropriate continuity of care;

d. regularly admit and care for inpatients and outpatients in the Hospital and are regularly involved in Medical Staff activities, including attendance at Department meetings; and

e. provide specialty call back-up and consultation as may be required by the Rules and Regulations.

3.2-2 PREROGATIVES

Except as otherwise provided the prerogatives of an Active Staff member shall be to:

a. admit patients and exercise such privileges as are granted pursuant to the Bylaws and the Rules and Regulations;

b. attend and vote on matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member;

c. hold Medical Staff and Department office and serve as chairman and/or a voting member of committees to which he/she is duly appointed or elected by the Medical Staff or duly authorized representative thereof;

d. be assigned to an appropriate Medical Staff department based upon clinical practice;

e. elect not to be included on the call schedule if they have been an Active Member for the past fifteen (15) years and who are aged 55 or more.

Provisional Active members may not vote or hold office or chairmanship until they have completed their provisional requirements as described in Section 4.7.

3.3 COURTESY STAFF

3.3-1 QUALIFICATIONS

A physician or dentist may be eligible for Courtesy Staff membership if he/she is an active staff member at his/her primary hospital, and if he/she plans to make significant use of Tahoe Forest Hospital and/or Incline Village Community Hospital's hospital services. When loss of membership at his/her primary hospital occurs, the practitioner shall automatically lose his membership and privileges at Tahoe Forest Hospital and/or Incline Village Community Hospital.

The Courtesy Staff Shall Consist Of Members:

a. who can demonstrate current competence and the maintenance of their knowledge and skills by documenting that they have routinely practiced in this or another acute care hospital, or another setting similarly calling for the exercise of their professional knowledge and skills, over the last twenty-four (24) months.

b. who meet the general qualifications set forth in Section 2.2 of the Bylaws; and,

c. Specific clinical privileges shall be applied for and restricted in the same manner as privileges of Active Staff members. At the time of appointment and every two years at the time of reappointment, a practitioner shall provide documentation

from his/her primary hospital. In the case of inpatients, the Courtesy Staff member shall find an appropriate active staff member who agrees to attend patients in case of an emergency where distance makes it impossible for the Courtesy Staff member to be at the patient's bedside in a reasonable time.

3.3-2 PREROGATIVES

Except as otherwise provided, the Courtesy Staff member: :

a. shall be entitled to admit patients and exercise such privileges as are granted pursuant to these Bylaws and the rules and regulations;

b. shall provide for continuous care of his/her patients;

c. shall be entitled to attend in a non-voting capacity meetings of the Medical Staff and the department and committees of which he/she is a member, but shall not have the right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;

d. shall be assigned to an appropriate medical staff department based on clinical practice, but shall be ineligible to hold medical staff office; and,

e. must pay application fees, dues and assessments to the medical staff.

3.3-3 TRANSFER TO ACTIVE STATUS:

Involvement in the care of greater than fifty (50) patients in a two (2) year period shall result in a transfer of the physician to the Active Staff. The applicant may petition the MEC for an exception. Consideration for exceptions may be given by the MEC on a case-by-case basis. Examples for consideration of an exception may include physician's working as hospitalists, emergency medicine, radiology, or pathology.

3.4 HONORARY STAFF

3.4-1 QUALIFICATIONS

The Honorary Staff shall consist of physicians, dentists, and podiatrists who do not practice at the Hospital, and who might not reside in the community, but are deemed deserving of membership by virtue of their outstanding reputation, and/or their previous service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct. Such individuals must be nominated by the Medical Executive Committee and/or clinical department and approved by the Board.

3.4-2 PREROGATIVES

Honorary Staff members are not eligible to admit or care for patients in the Hospital or to exercise privileges in the Hospital, or to vote or hold office in the Medical Staff. They may serve on Medical Staff committees, with or without vote, only at the discretion of the Medical Executive Committee. They may attend Medical Staff and Department meetings.

3.5 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership by other sections of the Bylaws and these Rules.

3.6 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, eligible podiatrists and dentists shall exercise admitting and clinical privileges only within the scope of their licensure and as set forth in Article V of these Bylaws.

3.7 MODIFICATION OF MEMBERSHIP

(a) On its own initiation or pursuant to a request by a member, the Medical Executive Committee may recommend a change in the Medical Staff status of a member consistent with the provisions of the Bylaws. Unless the change has been requested by the practitioner, the Medical Executive Committee shall afford the practitioner an opportunity to comment either in writing or in person before its recommendation is finalized and forwarded to the Board of Directors. There shall be no right to a Hearing under Article VII except as expressly provided therein or required by law.

(b) After two consecutive years in which a member of the Active Staff fails to regularly care for patients in the Hospital as required by that staff category, that member may be automatically transferred by the Medical Executive Committee to the appropriate Medical Staff category, if any, for which the member is qualified.

(c) Action may be initiated to evaluate and possibly terminate the privileges and membership of any staff member (except Honorary) who has failed to have any activity within the Hospital during the previous two years.

3.8 RESIDENT MEDICAL STAFF

3.8-1 QUALIFICATIONS

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

3.8-2 APPOINTMENT

a. Post-doctoral trainees who are enrolled in accredited residency training programs, with whom TFHD has a Memorandum of Understanding (MOU), and who meet the above qualifications shall be appointed to the resident medical staff. Members of the resident staff are not eligible to hold office within the medical staff but may participate in the activities of the medical staff through membership on medical staff committees, with the right to vote within committees if specified at the time of appointment, and non-voting attendance at medical staff meetings.

b. All medical care provided b resident medical staff is under the supervision of members of the Active Staff. Such care shall be in accordance with the provisions

of a program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation. Residents must be supervised by teaching staff in such a way that the trainee assumes progressively increasing responsibility for patient care according to their level of training, ability, and experience

c. Appointment to the resident medical staff shall be for one year and may be renewed annually. Resident medical staff membership may not be considered as the observational period required to be completed by provisional staff. Resident medical staff membership terminates with termination from the training program.

ARTICLE IV

APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person, including those in a medical-administrative position by virtue of a contract with the Hospital, shall exercise privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, the applicant agrees that during the credentialing process and throughout any period of membership that person will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the member only such privileges as have been granted in accordance with these Bylaws.

4.2 QUALIFICATIONS FOR INITIAL APPOINTMENT

Threshold Eligibility Criteria for Initial Appointment:

To be eligible to apply for initial appointment to the Medical Staff, physicians, dentists, and oral surgeons must meet all of the following:

(a) where applicable to their practice, have a current, unrestricted DEA registration;

(b) be located close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital, including the Emergency Department, if applicable;

(c) have current, valid professional liability insurance coverage in amounts of $1 million/$3 million, or such other amount established by Board policy.

(d) are not currently excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(e) agree to fulfill all responsibilities regarding emergency call established by the medical staff;

(f) have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable;

(g) have successfully completed a residency training program and be certified or eligible by an American Board of Medical Specialties (ABMS) member board in the specialty in which the applicant seeks clinical privileges; or by the American Osteopathic Association (AOA) in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(h) be board certified or qualified to sit for the boards in their primary area of practice at the Hospital subject to the recertification provision, below. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship

training are required to become board certified within five (5) years of residency or fellowship training[1];

(i) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements.[2] If a physician has not met the recertification requirements of his/her board for his primary specialty by the time the reappointment is required, the physician will have up to two (2) years from the date of his/her board's expiration to attain such recertification. If a physician does not meet the recertification requirements of his/her board by the end of this time, the physician shall not be eligible for reappointment;

An individual who does not meet the Medical Staff's board certification requirements may request a waiver. The individual requesting the waiver bears the burden of showing that:

(1) it would not be possible, with reasonable and good faith efforts, for him or her to become board certified, maintain board certification, or regain board certification, as applicable; and

(2) based on his or her qualifications, experience and demonstrated competence, he or she can be relied upon to provide care of the same quality and sophistication that is expected of those who have achieved initial board certified in the same specialty.

A request for a waiver must be submitted in writing to the Medical Executive Committee, and be accompanied by a written statement and relevant documentation in support if it. The MEC shall consider the request and make a recommendation to the Board. The MEC may give the practitioner an opportunity to make an oral presentation and respond to questions before formulating its recommendation. The denial of a waiver shall not entitle the practitioner to a hearing under Article VII of these Bylaws.

(j) demonstrate recent clinical activity in their primary area of practice by submitting a case list from the last two years.

[2] This provision shall only apply to physicians who were granted staff privileges on or after September 22, 2016, the date of initial adoption by the Board of Directors.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information necessary for a proper evaluation of the applicant's current competence, character, ethics, and other qualifications and suitability for the privileges and Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to complete his/her application will be grounds for a refusal to take action on that application, which shall not be subject to appeal or review under Article VII of these Bylaws.

[1] The provision requiring board certification shall only apply to those physicians who were granted hospital privileges on or after September 22, 2016, the date of adoption by the Board of Directors.

In order for the Medical Executive Committee to make a recommendation to the Board of Directors concerning an applicant for appointment or reappointment to the Medical Staff or additional clinical privileges, the Medical Staff must have in its possession adequate information for a conscientious evaluation of the applicant's training, experience and background as measured against the unique professional standards of this Hospital. Accordingly, the Medical Staff will not take action on an application that is not "complete."

4.2-1. COMPLETE APPLICATION FOR APPOINTMENT, REAPPOINTMENT, OR NEW PRIVILEGES

An application for appointment, reappointment or new clinical privileges shall not be deemed "complete," for purposes of subparagraph 4.2-3 below, until:

a. The applicant submits a written application, using the prescribed form, in which all of the requisite information is provided. All entries and attachments must be legible, understandable and substantively responsive on every point of inquiry.

b. The applicant responds to all further requests from the Medical Staff, through its authorized representative, for clarifying information or the submission of supplementary materials. This may include, but not necessarily be limited to, submission to a medical or psychiatric evaluation, at the applicant's expense, if deemed appropriate by the Medical Executive Committee to resolve questions about the applicant's fitness to perform the physical and/or mental functions associated with requested clinical privileges. If the requested items of information or materials, such as reports or memoranda, are in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain them or to arrange for them to be submitted to the Medical Staff directly by the source.

c. The applicant has assisted as necessary in the solicitation of written evaluations from those listed by the applicant as references and from other potential sources of relevant information. Such assistance may include the signing of a special release or similar document, as requested.

4.2-2 COMPLETE APPLICATION FOR NEW OR ADDITIONAL PRIVILEGES

An application for new or additional privileges by a member of the Medical Staff in good standing, for which there might or might not be a prescribed form, shall not be complete unless and until:

a. The applicant submits a written request for privileges, supported by a complete description of the applicant's training, experience and other qualifications for the requested privileges, with documentation as appropriate.

b. The applicant responds to requests for information and materials as described above.

4.2-3 INCOMPLETE APPLICATION

An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Notwithstanding any other provision of these Bylaws, an

application that is determined to be incomplete shall not qualify for credentialing 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 being given a reasonable opportunity to do so, the credentialing process will be terminated, at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing or at a meeting, as determined by the Medical Executive Committee. An incomplete application will not be processed. Termination of the credentialing process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

4.2-4 APPLICANT RESPONSIBILITY FOR KEEPING APPLICATION CURRENT

Until notice is received from the Board of Directors regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Medical Staff, in writing, of any material change in the information provided or new information that might reasonably have an effect on the applicant's candidacy, including the filing of any malpractice claim against the applicant. Failure to meet this responsibility shall be grounds for denial of the application, nullification of any approval if granted, and/or termination of Medical Staff Membership.

4.2-5 COMPLETED APPLICATION TIME PERIOD

A complete application shall be acted upon within a reasonable time period not to exceed 60 days except that action by the Board of Directors may be delayed for a good cause.

4.2-6 SIGNIFICANT MISREPRESENTATIONS OR OMISSIONS

An applicant may be given an opportunity to render an incomplete application complete as described above. However, it is the applicant's absolute responsibility to review the application carefully and verify that the information provided in it, or as part of it, is accurate and complete before it is submitted. Any substantial misrepresentation or misstatement in, or omission from, an application shall, in itself alone, constitute cause for denial of the application. Similarly, in the event that any substantial misrepresentation or misstatement in, or omission from, an application is discovered after the application has been approved; it shall constitute cause for summary suspension and/or immediate revocation of Medical Staff membership and/or all clinical privileges. This provision may be invoked by the Medical executive Committee, at is discretion, after giving the applicant an opportunity to address the issues in writing or at a meeting.

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4.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, appointments to the Medical Staff shall be for a period of two years. Reappointments shall be for a period of up to two years.

4.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

An applicant for appointment and reappointment shall complete written application forms that request information regarding the applicant and document the applicant's agreement to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws

and Rules. Following its investigation, the Medical Executive Committee shall recommend to the Board of Directors whether to appoint, reappoint, and/or grant specific privileges.

4.5 BASIS FOR APPOINTMENT AND REAPPOINTMENT

Recommendations for appointment to the Medical Staff and for granting of privileges shall be based upon the applicant's training, experience and professional performance at this Hospital and in other settings, whether the applicant meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the Rules, and upon the Hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner. Evidence of the applicant's identity, character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current chiefs or chairmen at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

4.5-1. APPLICATION FORM

An application form shall be developed by the Hospital and the Medical Staff. The form shall require detailed information which shall include but not be limited to, information concerning:

a. the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, Nevada pharmacy certificate and fluoroscopy certificate as appropriate, professional affiliations, and continuing medical education information related to the privileges to be exercised by the applicant;

b. peer references (at least three), some of whom are in the same specialty, who have had extensive experience in practicing with, or otherwise observing, the applicant and who are therefore familiar with the applicant's current professional competence and ethical character; no more than one reference may be from a practitioner with whom the applicant is currently in practice or would be in practice upon obtaining membership;

c. requests for Medical Staff status, Department affiliation, and privileges;

d. any past or pending, voluntary or involuntary, professional disciplinary actions, licensure, DEA Permit, or Nevada certificate limitation; federal or state investigations, or related matters;

e. physical and mental status relative to the clinical privileges requested;

f. professional liability insurance coverage which shall be maintained in effect in limits set in accordance with these Bylaws;

g. a detailed description of any proposed or implemented restrictions or denial of licensure or governmental certification or registration;

h. a description of any suspension or termination of specialty board certification or eligibility;

i. a detailed description of any professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition against the applicant; any additional information concerning such proceedings or actions as the Medical Executive Committee, or the Board of Directors may request; and

j. A current valid state or federal agency photo identification card (passport or driver's license) or, at the discretion of the Medical Staff, a current valid Hospital picture ID card, in order to verify that the applicant is the same practitioner identified in the credentialing documents.

Each application for initial appointment to the Medical Staff shall be in writing, or electronically submitted on the prescribed form with all provisions completed, and signed by the applicant.

4.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 4.1 of the Bylaws, by applying for appointment to the Medical Staff each applicant:

a. signifies his/her willingness to appear for interviews in regard to the application;

b. authorizes consultation with others who may have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes those individuals and organizations to candidly provide that 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 the privileges and status 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 permitted by the law, all persons for their acts performed in connection with investigating and evaluating the applicant, all individuals and organizations who provide information regarding the applicant, including information otherwise deemed confidential;

e. consents to the disclosure, upon appropriate request, to other hospitals, medical associations, licensing boards, and to any other relevant organization, of any information regarding the applicant's professional or ethical standing that the

Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for doing so to the fullest extent permitted by law;

f. acknowledges responsibility for timely payment of Medical Staff dues as specified by the Medical Staff in accordance with the Bylaws and these Rules;

g. pledges to provide for continuous quality care for patients;

h. pledges to maintain an ethical practice, including refraining from illegal inducements for patient referrals, providing continuous care of his/her 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;

i. pledges to be bound by the Medical Staff Bylaws, Rules, and policies;

j. acknowledges that any omission or falsification of information may result in denial of an application;

k. consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee; and

l. signifies his/her willingness to abide by all the conditions of membership, as stated on the application form, the reapplication form, and in these Rules.

4.5-3 APPLICATION FEE

The applicant shall deliver a completed application to the Chief of Staff or his/her designee, a non-refundable application fee, and any dues per Medical Staff Policy.

4.5-4 VERIFICATION OF INFORMATION

The Chief of Staff and the Chief Executive Officer 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 Hospital's Authorized Representative shall query the National Practitioner Data Bank, the appropriate state medical board(s), and other relevant sources, such as but not limited to the Federation of State of Medical Boards Physician Disciplinary Data Bank, regarding the applicant and include any resulting information in the applicant's credentials file. The Medical Staff Office shall also obtain such additional information or documentation as necessary to confirm that the individual requesting membership and privileges is the same individual identified in the credentialing documents. After the application is completed, the application and incidental credentialing materials shall be transmitted to the chair of each Department in which the applicant seeks privileges. The applicant shall

be notified of any difficulties encountered in obtaining the information required, and it shall be the applicant's obligation to obtain the required information.

4.5-5 HEALTH INFORMATION

Information regarding the applicant's health status shall be immediately transferred to the custody of the Well-Being Committee, and shall not be considered by the Medical Executive Committee until after the applicant has otherwise been determined to qualify for membership.

4.6 ACTION ON THE APPLICATION

4.6-1 DEPARTMENT ACTION

After receipt of the application, the Department to which the application has been submitted shall review the application and the incidental credentialing materials. This review shall be conducted by the chairperson of the Department with the optional assistance of an ad hoc committee of members of the Department. That ad hoc committee is to be selected by the chairperson and membership shall be open to all members of the Department who are interested in contributing to the credentialing process. As part of this process, the applicant may be required to attend a personal interview with a representative of the Department. The chairperson of the Department shall then transmit to the Medical Executive Committee a written report and recommendation of the Department as to appointment and, if appointment is recommended, concerning the applicant's qualifications for the request for clinical privileges, applicant's character, professional competency, prior behavior and ethical standing and whether the applicant has established and satisfied all of the necessary qualifications for appointment. Included in the report shall be recommendation as to membership category, Department affiliation, privileges to be granted and any special conditions to be attached.

If the chairperson of the Department is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise considered incomplete under Section 4.2, the chairperson may delay further processing of the application, or may begin processing the application based only on the available information with an indication that further information may be considered upon receipt (this latter section referring only to particular clinical privileges requested that cannot be acted upon until requested documentation or other information is received). If the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the application shall be considered incomplete under Section 4.2 and the affected practitioner shall be so informed. Such an applicant's application may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.

4.6-2 MEDICAL EXECUTIVE COMMITTEE ACTION

After receipt of the Departmental report and recommendation, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Department for further review, and/or elect to interview the applicant. As part of making its recommendation, in the manner and to the extent permitted by law, the Medical Executive Committee may require the applicant to undergo a physical and/or mental

examination by a physician or physicians satisfactory to the Medical Executive Committee**.** The Medical Executive Committee shall then formulate a preliminary recommendation. If the preliminary recommendation is favorable, the Medical Executive Committee shall then assess the applicant's health status, including any reports of the Well-Being Committee, and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical Staff. The Medical Executive Committee shall then finalize a recommendation regarding the application**.** The Medical Executive Committee may also defer action on the application but not indefinitely and shall be addressed at the next regularly scheduled meeting. The reasons for each recommendation should be stated.

4.6-3 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

a. **Favorable Recommendation.** Favorable recommendations shall be promptly forwarded to the Board of Directors together with the supporting documentation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

b. **Adverse Recommendation.** When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the applicant, and he/she shall be entitled to the procedural rights as provided in Article VII of the Bylaws. The Board of Directors shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

4.6-4 BOARD OF DIRECTORS ACTION

a. **On Favorable Medical Executive Committee Recommendation.** The Board of Directors shall adopt, reject, or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond.

b. If the board is inclined to reject or modify a favorable recommendation, the Board shall refer the matter back to the Medical Executive Committee for further review and comments, which may include a second recommendation**.** The Executive Committee's response shall be considered by the Board before adopting a resolution.

c. If the Board's resolution constitutes grounds for a hearing under Article VII of the Bylaws, the Chief Executive Officer shall promptly inform the applicant, and he/she shall be entitled to the procedural rights as provided in that Article.

d. **After Procedural Rights.** In the case of an adverse Medical Executive Committee recommendation pursuant to Section 4.6-3 (b) or an adverse Board decision pursuant to Sections 4.6-4 (a) or (b), the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights under the Bylaws. Action thus taken shall be the conclusive decision of the Board, except

that the Board may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Board of Directors shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Board shall make a final decision.

e. **Conflict Resolution.** The Board of Directors shall give great weight to the actions and recommendations of the Medical Executive Committee and in no event shall act in an arbitrary and capricious manner.

f. The Governing Body may delegate decision-making authority to a committee of the Governing Body; however, any final decision of the Governing Body committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting.

4.6-5 NOTICE OF FINAL DECISION

a. Notice of the final decision shall be given to the Chief of Staff, the Medical Executive Committee, the applicant, and the Chief Executive Officer.

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

4.6-6 TIMELY PROCESSING OF APPLICATIONS

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. 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.

4.7 PROVISIONAL STATUS

4.7-1 OBSERVATION OF PROVISIONAL STAFF MEMBERS

a. Each new member of the Medical Staff shall be observed, or proctored, by one or more appropriate member(s) of the Active or Courtesy Staff per Medical Staff Policy. The proctor shall monitor the practitioner's performance and evaluate the member's (1) proficiency in the exercise of privileges initially granted and (2) overall eligibility for continued Medical Staff membership and clinical privileges and advancement within Medical Staff Categories.

b. Proctoring will be reported on forms setting forth criteria to be used by proctors in evaluating performance. Included in the criteria to be evaluated shall be professional skill and judgment, cooperation with other professionals and Hospital staff, timely and thorough completion of medical records, and ethical conduct. Observation shall include those mechanisms customarily used to evaluate a practitioner's initial

performance including, but not necessarily limited to, concurrent chart review, retrospective chart review, discussion, and proctoring by direct visual observation. The respective obligations of the observer and the practitioner being observed may be established in more detail through department clinical privileges criteria description, department rules, and/or medical staff policies. Although flexibility in the proctoring process is to be stressed, policy guidelines should require the timely completion of written evaluation forms.

c. A proctor may intervene in the care of a patient only if he or she believes that an error is being made that either may be life-threatening or that may result in permanent harm. In such circumstances, the proctored physician must step aside and/or follow the proctor's orders.

d. Proctoring may be concurrent or retrospective depending upon the nature of the privileges requested. A department may utilize an external proctor who is not a member of the Medical Staff if it is necessary to monitor a physician in a procedure not currently being done by other physicians on the staff. Medical Staff policies will define the process for proctoring by a practitioner not on the Medical Staff.

e. In the event of an unsatisfactory proctoring report, the practitioner being proctored shall be notified and shall be afforded an opportunity to have an informal conference with his/her Department chair concerning such report, provided, however, such opportunity shall not include access by the practitioner being proctored to written proctoring reports which shall be maintained as part of the peer review activities of the Medical Staff and shall be kept in strictest confidence unless or until such reports are used to deny or restrict privileges; then they shall be made available to the proctored physician.

f. Proctoring of practitioners with temporary privileges shall be performed pursuant to Section 5.4-3.

4.7-2 DURATION OF PROVISIONAL STATUS

a. All initial appointments to the Medical Staff shall be provisional for a period of no less than six (6) months and no more than twenty-four (24) months as provided for in these bylaws, and new appointments and/or practitioners granted new privileges shall be subject to proctoring in accordance with standards and procedures set forth in these bylaws. If, at the end of twenty-four (24) months, the practitioner has not satisfied the requirements for advancement to full Active or Courtesy Staff for unsupervised privileges, the Medical Executive Committee may recommend to the Board of Directors that membership and privileges not be extended beyond the expiration of the current term of appointment. However, if during this provisional period, a staff member has met the ethical requirements for continued membership and has otherwise discharged all assigned obligations, but, for reasons beyond his control (e.g., practice seldom requires a hospital utilization), he has not been proctored or observed sufficiently to accommodate an evaluation of current

competence for all of the requested clinical privileges, he may be granted a six (6) month extension of the provisional membership.

b. Advancement to the full Courtesy or Active Staff may be granted with some privileges remaining under proctorship as recommended by the Medical Executive Committee should the provisional privileges not be utilized.

c. A lapse of membership or clinical privileges by reason of the expiration of the maximum term of this provisional period shall not give rise to formal hearing rights, unless it is under circumstances which require a report to the Medical Boards of California or Nevada, Osteopathic Medical Boards of California or Nevada or the National Practitioner Data Bank, or the dental or podiatric boards of either California or Nevada.

d. Members of the provisional staff are required to fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities..

e. In addition, members may be required to be proctored as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competence in that area).

Proctoring may also be implemented whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance. Proctoring is not viewed as a disciplinary measure, but rather is an information-gathering measure. Therefore, it should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment. Proctoring does not give rise to the procedural rights described in Article VII of these Bylaws unless the proctoring has the effect of restricting a practitioner's privileges because the proctoring is imposed for reasons other than assessment of new or infrequently performed privileges and carries the condition that procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor.

f. The practitioner shall remain subject to such proctoring until the Medical Executive Committee has been furnished with a report signed by the chair of the Department to which the member is assigned describing: (i) that competencies are met and no further proctoring is necessary; (ii) the types and numbers of cases observed and the evaluation of the applicant's performance; (iii) a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that Department, with any exceptions noted, has discharged all of the responsibilities of membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made, and (iv) any adverse information or recommendation based on review of the proctoring reports with follow up as described in 4.7-2**.** In all cases, the Medical Executive Committee shall make its recommendation to the Board of Directors regarding approval**,** modification or termination of privileges and Medical Staff membership.

4.8 REAPPOINTMENT

Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member's performance at this Hospital and in other settings. The reappraisal is to include confirmation of adherences to the Medical Staff membership requirements as stated in these Bylaws, the Medical Staff Rules, the Medical Staff and Hospital policies, and the applicable department rules. Such reappraisal should also include relevant practitioner-specific information from performance improvement activities and where appropriate comparisons to aggregate information about performance, judgment and clinical technical skills. Where applicable, the results of specific peer review activities shall also be considered.

Reappointments are granted for a period not to exceed two years and may be granted for less than two years as recommended by the Medical Executive Committee.

4.8-1 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

a. At least four (4) months prior to the expiration date of the current Medical Staff appointment, a reapplication form developed by the Hospital and Medical Staff shall be mailed or delivered to the member. The completed reappointment application must be returned to the Medical Staff Office within 30 days of receipt. Upon receipt of the application, it shall be processed in the manner described in Section 4.5-4 through 4.5-10 of these Bylaws.

b. A Medical Staff member who seeks a change in Medical Staff status, category or modification of privileges by submitting a written request through Medical Staff Services may submit such a request at any time except that such application may not be filed within two (2) years of the time a similar request has been denied. Such application shall be processed in substantially the same manner as provided in these Bylaws regarding initial applications for Appointment. The exercise of new privileges by medical staff members shall be subject to observation in accordance with procedures adopted by the Medical Staff.

4.8-2 EFFECT OF REAPPOINTMENT APPLICATION

Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such member's:

a. Relevant practitioner specific information from organization performance improvement activities, including morbidity and mortality data, is considered and compared to aggregate information when these measurements are appropriate for comparative purposes in evaluating professional performance;

b. Results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty;
c. Any focused professional practice evaluations;
d. Verified complaints received through documentation from patients and/or staff;
e. Compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and Hospital;

f. Participation in Medical Staff duties, including committee assignments and emergency call;
g. Demonstrated ethical behavior and clinical competence, current licensure, National Practitioner Data Bank query and receipt of response, and clinical judgment including professional and technical skills, in the treatment of patients.
h. Other reasonable indicators of continuing qualifications.

4.8-3 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a complete application for reappointment (i.e., failure to return the application within the time required by Section 4.8-1 and to make the application complete within sufficient time for it to be processed) shall result in the automatic expiration of the practitioner's Medical Staff membership and clinical privileges at the end of the current Medical Staff appointment. In the event membership terminates for the reasons set forth herein, the member shall not be entitled to any hearing or review as set forth in Article VII of the Bylaws.

4.9 LEAVE OF ABSENCE

4.9-1 REQUEST FOR LEAVE STATUS

a. Routine Leave of Absence

At the discretion of the Medical Executive Committee, a Medical Staff member may request a voluntary leave of absence from the Medical Staff upon submitting a written request to the Medical Executive Committee no less than thirty (30) days prior to the requested effective date of the leave of absence, 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 relinquishment of medical staff appointment and clinical privileges, unless an extension is requested in writing at least forty-five (45) days prior to the end of the leave and granted by the Medical Executive Committee with TFHD Board of Directors approval. The Medical Executive Committee shall act on such requests, using its sole discretion as to whether the requested leave of absence is in the best interests of the Hospital and the Medical Staff. Leave of absences must be requested if the Medical Staff member is going to be absent from practice for more than sixty (60) days. There shall be no right to a leave of absence; nor shall there be any procedural rights associated with failure to obtain approval for a requested leave. The member shall be notified in writing of the Medical Executive Committee decision and is only effective upon acceptance of the Medical Executive Committee.

b. Medical Leave of Absence

The Chief of Staff, in consultation with the appropriate department chair, may approve a medical leave of absence of any duration to accommodate a member's treatment for, or recovery from, a mental or physical condition affecting his or her fitness to practice safely. The member shall be notified in writing by the Chief of Staff granting the leave. The member may be required to submit a letter of release from the treating physician as a condition of return from such leave of absence and prior to exercising any patient care.

4.9.2 OBLIGATION UNDER LEAVE OF ABSENCE

During the period of the leave, the member shall not exercise privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless excused 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 excused by the Medical Executive Committee. Meeting attendance requirements will be waived during period of leave.

4.9-3 EXTENSION OR TERMINATION OF LEAVE

At least thirty (30) days prior to the proposed termination of the leave of absence, or at any earlier time, the Medical Staff member may request extension of the leave or reinstatement of privileges by submitting a written request to the Medical Executive Committee. The member shall submit a summary of relevant activities during the leave. The Medical Executive Committee shall make a recommendation concerning the extension of the leave or reinstatement of the member's privileges and prerogatives, and the procedures provided in Section 4.5 and 4.7 of these Bylaws shall be followed, including processing as a full reappointment under Section 4.8 if the time period since the member's appointment or last reappointment is eighteen (18) months or greater or if the member's appointment or last reappointment is expired.

4.9-4 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall result in automatic expiration of membership and clinical privileges. A member whose membership 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 shall be final. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments.

4.9-5 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

If a member's term of appointment is scheduled to expire during the period for which a leave is requested, the member may: (i) seek and obtain reappointment prior to going on leave and before the expiration of the member's current term, which would result in an adjustment of the member's subsequent term of appointment to reflect the new date of reappointment; (ii) apply for reappointment at the scheduled time while on leave, subject to the Medical Staff's prerogative that supplemental information be produced to confirm current competence upon reinstatement; (iii) or permit the current term of appointment to expire and reapply for membership and privileges as a new candidate upon termination of the leave of absence.

4.10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment or reappointment to the Medical Staff shall not be eligible to apply again to the Medical Staff for a period of two years. Any such application shall be processed as an initial application, and the applicant shall submit any additional information that may be required to demonstrate that the basis for the

earlier adverse action no longer exists along with any other information needed to demonstrate his/her qualifications.

4.11 CONFIDENTIALITY, IMPARTIALITY

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to committee meetings and the formal processes provided in these Bylaws for processing applications for appointment and reappointment.

ARTICLE V

CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a practitioner providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted. Those privileges and services shall be specifically delineated for each facility operated by the Hospital, and must be within the scope of any license, certificate, or other legal credential authorizing practice and consistent with any restrictions thereon. Privileges may be granted, continued, modified, or terminated by the Board of Directors only in accordance with the provisions of the Medical Staff Bylaws.

5.2 BASIS FOR PRIVILEGES DETERMINATION

Requests for privileges shall be evaluated on the basis of the applicant's education, training, experience, demonstrated professional competence and clinical performance, and the other factors specified in these Bylaws regarding qualifications for membership and privileges.

5.3 ADDITIONAL CONDITIONS FOR PRIVILEGES OF Dentists, ORAL SURGEONS, AND PODIATRISTS

5.3-1 ADMISSIONS

Dentists, oral surgeons and podiatrists who are members of the Medical Staff may only admit patients if an Active or Courtesy physician member of the Medical Staff performs the admitting history and physical examination, except the portion directly related to dentistry or podiatry, and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

5.3-2 SURGERY

a. Surgical procedures performed by dentists, oral surgeons, and podiatrists shall be under the overall supervision of the Chair of the Department of Surgery or the Chair's designee.

b. (b)Additionally, the finding, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior to major high-risk (as defined by the responsible department) diagnostic or therapeutic interventions.

5.3-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist, oral surgeon, or a podiatrist shall receive the same basic medical appraisal as patients admitted for other care, and a physician member of the Medical Staff shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s). This action affords no right to appeal or review under Article VII of these Bylaws.

5.4 TEMPORARY CLINICAL PRIVILEGES

5.4-1 GENERAL

Temporary privileges may be granted by the Chief Executive Officer of the Hospital or his designee on the recommendation of the department chairman and the Chief of Staff under certain circumstances to practitioners who are not members of the Medical Staff under the terms and conditions described in 5.4-2 and 5.4-3 below. Temporary privileges may be granted here for a specific period not to exceed ~~ninety~~ one hundred and twenty (~~90~~120) consecutive days. Approval should be sought sufficiently in advance of the anticipated exercise of privileges to allow for collection and evaluation of such information in the normal course of Hospital business.

In all instances, prior to the granting of temporary privileges, there shall be:

a. a written request for temporary privileges;

b. a completed application form;

c. queries to and results from the National Practitioner Data Bank; Medical Board of California, Osteopathic Medical Board of California and/or State of Nevada, Board of Dental Examiners for California and/or Nevada, or appropriate licensing Boards for Podiatry in California and/or Nevada;

d. verification of DEA for California and/or Nevada and/or Nevada State Pharmacy registration depending upon practice location;

e. fluoroscopy certificate if applicable

f. verification of professional liability insurance meeting Medical Staff and Board of Directors specifications

g. query for and receipt of criminal background check

h. professional references for competency from previous hospital affiliation, chief or department chair familiar with the applicant's background and practice relevant to the requested temporary privileges per credentialing policy

i. other information as may be required per credentialing policy

j. evidence of no current or previously successful challenge to licensure or registration

k. evidence of no subjection to involuntary termination of medical staff membership at another organization

l. no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

m. A current valid state or federal agency picture ID card (passport or driver's license) or, at the discretion of the Medical Staff, a current valid Hospital picture ID card, in order to verify that the applicant is the same practitioner identified in the credentialing documents.

For new applicants for Medical Staff Membership and Clinical Privileges, a completed application is required which includes the above information as well as references below in 5.4-2 (a).

5.4-2 CIRCUMSTANCES

a. Pendency of Application – Temporary privileges for new applicants may be granted while awaiting review and approval by the Medical Executive Committee and Governing Board provided the application meets the criteria listed in the description above, Sections 4.2-1 and 4.5-1of these Bylaws.

b. Care of Specific Patient - A practitioner with specialized skills and experience not otherwise available on the Medical Staff or a practitioner not on the medical staff who is requested to assist with patient care by a member of the Medical Staff may be granted temporary privileges to care for a specific patient. Should the time period exceed ~~ninety~~ one hundred and twenty (~~90~~120) days, a time limited extension of temporary privileges may be granted based on documented special circumstances, These practitioners shall have no admitting or attending physician responsibilities.

c. Locum Tenens – A practitioner who is requested by a medical staff member to cover an expected absence may be granted temporary privileges per 5.4-2 (a) above.

d. Temporary adjuncts (proctoring physician and/or visiting professor) may be granted temporary privileges for the introduction of new procedures; all outside proctors must acquire temporary privileges.

e. Other circumstances that are necessary to fulfill an important patient care need that mandates an immediate authorization to practice shall be considered for temporary privileges.

5.4-3 CONDITIONS

There is no right to temporary privileges. Temporary privileges may be granted only when the practitioner has submitted a written application for appointment to the Medical Staff, or a written request for temporary privileges, and the information available reasonably supports a favorable determination regarding appointment or the practitioner's qualifications, respectively, and the applicant has satisfied the insurance requirements of

these Bylaws or Rules. The Chair of the Department to which the practitioner is assigned, or to which the privileges correspond, shall be responsible for determining the proctoring requirements or supervising the performance of any practitioner granted temporary privileges, or for designating a member of the Department to assume this responsibility. Special requirements of consultation and proctorship may be imposed by the Chair of that Department or the Medical Executive Committee. Temporary privileges will not be granted before the practitioner has acknowledged in writing that he/she has received, or has been given access to, the Medical Staff Bylaws and Rules and that he/she agrees to be bound by their terms in all matters relating to his/her Medical Staff status and the temporary privileges.

5.4-4 TERMINATION

Temporary privileges may be terminated without cause at any time by the Chief of Staff, the responsible Department Chair, or the Chief Executive Officer with the concurrence of the Chief of Staff or the responsible Department Chair. In addition, where the life or well being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Section 6.3. In the event of any such termination or restriction, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Chair of the concerned Department. The wishes of the patient will be considered, where feasible, in choosing an alternative practitioner.

5.4-5 RIGHTS OF THE PRACTITIONER

Except in cases where denial, termination, or suspension of temporary privileges must be reported to the National Practitioner Data Bank or the Medical Board of California, a practitioner or allied health professional shall not be entitled to the procedural rights afforded by Article VII because of his/her inability to obtain temporary privileges or because of any termination, suspension, or non-renewal of temporary privileges.

5.5 EMERGENCY PRIVILEGES

(a) In the case of an emergency, any member, to the degree permitted by his/her license and regardless of Departmental assignment, Medical Staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the Department Chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate privileges, and once the emergency has passed or assistance has been made available, shall defer to the Department Chair with respect to further care of the patient at the Hospital.

(b) In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when one becomes available.

5.6 DISASTER PRIVILEGES

(a) Disaster privileges may be granted to a non-Medical Staff member when the organization has activated its Emergency Management Plan and has determined that there are important and immediate patient care needs the Hospital is unable to meet without the assistance of practitioners in addition to those currently holding Medical Staff

membership and/or clinical privileges. The Hospital Chief Executive Officer or designee, upon recommendation of the Chief of Staff or designee, may grant disaster privileges should the need arise.

(b) Privileges shall be considered on a case-by-case basis upon presentation of a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

1. A current picture hospital ID badge (card) from a hospital where the practitioner holds clinical privileges that clearly identifies professional designation;

2. A current license to practice, or primary source verification of such license;

3. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);

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

5. Identification by current hospital or medical staff member(s) who possess personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

(c) Written notification/signed approval evidencing the granting of privileges shall be directed to Medical Staff Services to initiate verification. Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization. (Note: In the extraordinary circumstance that primary source verification cannot be completed within 72 hours, it must be done as soon as possible with documentation as to (i) why it could not be performed within the required time frame, (ii) evidence of demonstrated ability to continue to provide adequate care, treatment, and services and (iii) an attempt to rectify the situation as soon as possible).

(d) The practitioner who has been granted disaster privileges will be provided an identification badge or other designated means of identification, to be worn during the emergency. Specific means of organization-wide communication as designated by the incident commander (Hospital Chief Executive Officer or designee) will be utilized to disseminate basic information about non-Medical Staff member volunteer practitioners.

(e) The volunteer practitioner shall be assigned to a department of the Medical Staff under the supervision of the department chair or designee. The frequency and intensity of data collection and analysis shall be accelerated as appropriate to the emergency situation to evaluate clinical competence.

(f) The following information must be obtained, verified as soon as possible, and retained as a permanent record by Medical Staff Services:

1. Current professional license to practice including sanctions, if any
2. Photo identification, as specified above in (b)

3. Certificate of professional liability coverage
4. Current hospital affiliations
5. NPDB query (includes OIG, state sanction info, board certification, DEA information)
6. Relevant training/experience
7. Criminal background check

5.7 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, or pursuant to a member's request, the Medical Executive Committee may recommend a change in the privileges or Department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in the Rules regarding proctoring.

5.8 LAPSE OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges or department assignment fails to furnish, in a timely manner, the information necessary to evaluate the request, the application shall be regarded as incomplete under Section 4.2 and shall not qualify for a credentialing recommendation. The applicant shall not be entitled to a hearing under Article VII.

5.9 CONFIDENTIALITY, IMPARTIALITY

To maintain confidentiality, and to assure the unbiased performance of privilege review functions, Medical Staff members participating in the credentialing process shall limit their discussion of the matters involved to committee meetings and the formal processes provided in these Bylaws for processing applications for clinical privileges.

5.10 ALLIED HEALTH PROFESSIONALS

5.10-1 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Allied health professionals (AHPs) are not eligible for Medical Staff membership. They may be granted practice privileges if they hold a license, certificate, or other legal credential in a category of AHPs that the Board of Directors (after securing Medical Executive Committee recommendations) has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Allied Health Professional Manual. The Allied Health Professional Manual is incorporated herein by reference, as part of the Medical Staff Bylaws.

5.11 TELEMEDICINE PRIVILEGES

After consulting with the Medical Executive Committee, the Board of Directors may approve specific types of telemedicine services to be utilized at the Hospital. Such services may be provided pursuant to a contract. Practitioners who wish to provide permitted types of telemedicine services will be credentialed in accordance 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.

5.11-1 TELEMEDICINE CREDENTIALING

a. In processing a request for telemedicine privileges, the Medical Staff and Hospital may follow the normal credentialing process described in Article IV 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 this Section 5.11.

b. Telemedicine privileges shall be for a period not to exceed two 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 Hospital 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 Section 2.6 of these Bylaws, modified only to take into account their distance from the Hospital.

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.

5.11-2 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 Hospital's Board of Directors 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 Hospital and, in accordance with 42 CFR §485.635(c) (4) (ii), furnishes services in a manner that permits this Hospital to be in compliance with the Medicare Conditions of Participation.

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 at 42 CFR §485.616(c).

c. The distant-site entity acknowledges, or the Hospital 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 (currently 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 Hospital 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 Hospital.

f. The Medical Staff of this Hospital performs, and maintains evidence of, peer review of the distant-site practitioners' performance as it relates to Hospital 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 Hospital will provide must include all adverse events that result from the telemedicine services provided by the distant-site practitioners to this Hospital's patients, and all complaints this Hospital has received about the distant-site practitioners.

ARTICLE VI

CORRECTIVE ACTION

6.1 ROUTINE MONITORING AND CRITERIA FOR INITIATION OF AN INVESTIGATION

6.1-1 ROUTINE MONITORING AND PEER REVIEW

Medical Staff departments and committees are responsible for carrying out delegated peer review and quality assessment functions. 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) in the course of carrying out those delegated peer review functions 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 Medical Staff minutes or Medical Staff reports. Medical Executive Committee approval is not required for such actions. 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.

6.1-2 CRITERIA FOR INITIATION OF AN INVESTIGATION

Any person may provide information to the Medical Staff about the conduct, performance or competence of a Medical Staff Member. The Chief of Staff, a department chair, or the Chief Executive Officer may request, or the Medical Executive Committee may undertake on its own initiative, an investigation of a Member under this Article whenever reliable information indicates the Member may have exhibited acts, demeanor, or conduct reasonably likely to be 1) detrimental to patient safety or to the delivery of quality patient care within the hospital; 2) unethical, unprofessional or illegal; 3) contrary to the Medical Staff Bylaws, Rules and Regulations, or Medical Staff and Hospital administrative policy; 4) below applicable professional standards or the standards of the Medical Staff; or 5) disruptive of Medical Staff or hospital operations and the delivery of patient care.

6.2 INVESTIGATION

An investigation under these Bylaws ("Investigation") means a process specifically initiated by the Medical Executive Committee, or by the Chief of Staff on its behalf, based upon information indicating that a Member has exhibited acts, demeanor or conduct as described above in Section 6.1-2. An Investigation does not include the usual activities of departments or other committees of the Medical Staff, including the usual peer review, quality assessment and improvement activities undertaken by the Medical Staff in compliance with the licensing and certification requirements for health facilities set forth in Title 22 of the California Code of Regulations, the activities of the Medical Staff Aid Committee, or preliminary deliberations or inquiries of the Medical Executive Committee or its representatives to determine whether to order an Investigation.

6.3 INITIATION

A request for action or for an Investigation under the auspices of the Medical Executive Committee must be supported by reference to specific activities or conduct alleged. The Medical Executive Committee shall determine how to proceed. The Chief of Staff may act on behalf of the Medical Executive Committee to initiate an Investigation, subject to subsequent review and approval by that Committee. In addition, the Chief of Staff or any other Medical Staff official may, instead of initiating an Investigation, initiate or conduct such reviews as may be appropriate to his or her responsibilities under the Medical Staff's Bylaws, Rules and Regulations, or Policies.

If the Medical Executive Committee concludes an Investigation is warranted, it may conduct the investigation itself, or may assign the task to an appropriate Medical Staff official, Medical Staff department, or standing or Ad Hoc Committee of the Medical Staff. The Medical Executive Committee may in its discretion appoint members of Administration and practitioners who are not members of the Medical Staff for the purpose of assisting a standing or Ad Hoc Committee conducting an Investigation. The Member shall, at an appropriate time, be notified that an Investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigator or investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such Investigation shall not constitute a "hearing," nor shall the procedural rules with respect to hearings or appeals apply. At the conclusion of the Investigation a written summary of the findings and recommendation(s) shall be forwarded to the Medical Executive Committee. Despite the status of any Investigation, at all times the Medical Executive Committee shall have the authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the Investigative process, or other action.

6.4 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the Investigation, the Medical Executive Committee shall make a decision which may include but is not limited to:

(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 Member's credentials file;

(b) Deferring action for a reasonable time where circumstances warrant;

(c) Issuing letters of admonition, censure, reprimand, or warning ("Letter of Reprimand"). In the event a Letter of Reprimand is issued, the affected Member may make a written response which shall be placed in the Member's file. Nothing herein shall be deemed to preclude a department or section chair, committee chair, or the Medical Executive Committee from issuing informal written or oral warnings outside of the mechanism for issuance of a Letter of Reprimand as described in these Bylaws;

(d) 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;

(e) Recommending reduction, modification, suspension or revocation of Clinical Privileges;

(f) Imposing a suspension or restriction of Clinical Privileges and/or Medical Staff membership for a duration of fourteen (14) days or less, after giving the Member written notice of the issues and an opportunity to be heard by the Medical Executive Committee;

(g) Summarily suspending or restricting Medical Staff membership and/or Clinical Privileges; and

(h) Taking other actions deemed appropriate under the circumstances, including such other actions as may be provided for in these Bylaws.

6.5 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 but shall take no action on the matter until the practitioner has either waived or exhausted his or her hearing rights.

(b) If the Medical Executive Committee decides not to take or recommend corrective action, or to take or recommended 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. The decision following the hearing shall be the final decision of the Hospital.

6.6 INITIATION BY BOARD OF DIRECTORS

If the Medical Executive Committee decides not to conduct an Investigation or otherwise initiate corrective action proceedings as set forth above, the Board of Directors may concur in the Medical Executive Committee's decision, or, if the Board of Directors reasonably determines the Medical Executive Committee's decision to be contrary to the weight of the evidence presented, the Board of Directors may consult with the Chief of Staff and thereafter direct the Medical Executive Committee to conduct an investigation or otherwise initiate corrective action proceedings. In the event the Medical Executive Committee fails to take action in response to a

directive from the Board of Directors, the Board of Directors may, after written notification to the Medical Executive Committee, conduct an investigation or otherwise initiate corrective action proceedings on its own initiative. Any such proceedings shall afford the Member the rights to which he or she is entitled under California law. If 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. The decision following such proceedings shall be the final decision of the Hospital.

6.7 SUMMARY RESTRICTION OR SUSPENSION

6.7-1 CRITERIA FOR INITIATION

a. A Member's Clinical Privileges may be summarily suspended or restricted where it is believed that the failure to take such action may result in an imminent danger to the health or safety of any individual, including current or future hospital patients. Such suspensions may be imposed as an interim or precautionary measure for the protection of patients and in the absence of complete information so long as prompt steps are taken to gather information and to determine whether the suspension should be continued or discontinued, or if other less restrictive action is appropriate.

b. The following persons are authorized to impose a summary suspension or restriction: The Chief of Staff; the Medical Executive Committee, or the Chair of the Department(s) in which the Member holds Privileges. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon notice to the Member, or sooner if necessary.

c. When none of the persons listed above is available to impose a summary suspension or restriction, the Board of Directors or its designee may take such action if the Board or its designee believes that a failure to do so would be likely to result in an imminent danger to the health or safety of any individual, including current or future hospital patients. Prior to exercising this authority, the Board of Directors must make a reasonable attempt to contact the Chief of Staff. Summary action by the Board of Directors which has not been ratified by the Chief of Staff within two (2) working days after the suspension, excluding weekends and holidays, shall terminate automatically without prejudice to further summary action as warranted by the circumstances.

d. The summary restriction or suspension may be limited in duration and shall remain in effect for the period and/or subject to the terms stated, or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another member by the department chair or appropriate clinical service chief or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute member.

e. Unless an Investigation of the suspended practitioner is already underway at the time the summary suspension or restriction is imposed, that action shall automatically constitute a request for Investigation or action pursuant to this Article. If the Medical Executive Committee imposed the summary suspension or restriction on its own initiative, it shall determine what, if any, Investigation and further actions are warranted.

6.7-2 WRITTEN NOTICE OF SUMMARY ACTION

As soon as possible after imposition of a summary suspension or restriction, the affected Medical Staff Member shall be provided with written notice of such action. This initial written notice shall include a statement of the reasons why summary action was deemed necessary. Notice of the suspension shall also be given to the Board of Directors and, as needed, the Medical Executive Committee and the Chief Executive Officer.

6.7-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within ten (10) days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The Member shall attend and make a statement concerning the issues, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the Member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The Medical Executive Committee shall determine whether the summary restriction or suspension should be continued and may modify, continue or terminate the summary restriction or suspension, but in any event it shall furnish the Member with notice of its decision within two working days of the meeting.

6.7-4 PROCEDURAL RIGHTS

If the summary restriction or suspension is not lifted, the Member shall be entitled to hearing rights to the extent provided under Article VII.

6.8 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's Privileges or membership may be suspended or limited as described below. A practitioner whose membership and/or Privileges have been suspended or limited pursuant to the provisions of this Section shall not be entitled to procedural rights afforded under Article VII. However, the Member shall be given an opportunity to be heard by the Medical Executive Committee related solely to the question whether grounds exist for the special action as described above; the Medical Executive Committee shall reverse any action that was based on a material mistake of fact as to the existence of the grounds for such special action. Additional actions taken by the Medical Executive Committee on a discretionary basis shall be subject to hearing rights to the extent provided by Article VII.

6.8-1 LICENSURE

Whenever a Member's license or other legal credential authorizing practice in this state:

a. is revoked or suspended, Medical Staff membership and Clinical Privileges shall be automatically revoked or suspended, as applicable, as of the date such action becomes effective and throughout its term.

b. is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. is placed on probation or made subject to restrictions by the applicable licensing or certifying authority, his or her membership status and Clinical Privileges shall

automatically become subject to the same terms and conditions of the probation or restrictions as of the date such action becomes effective and throughout its term.

d. lapses, expires or is not renewed by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the hospital shall be automatically suspended as of the date such expiration of licensure becomes effective. 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 Clinical Privileges.

6.8-2 CONTROLLED SUBSTANCES

Whenever a Member's DEA certificate:

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

b. is subject to probation or conditions, the Member's right to prescribe such medications shall automatically become subject to the same terms of probation or conditions, as of the date such action becomes effective and throughout its term.

6.8-3 MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Hospital and the Medical Staff. A limited suspension in the form of withdrawal of admitting and clinical privileges until medical records are completed shall be automatically imposed after notice of delinquency for failure to complete medical records within that period. The suspension shall continue until those medical records have been completed.

6.8-4 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments shall be grounds for automatic suspension of a Member's Clinical Privileges. Such suspension shall take effect automatically if the dues and assessments remain unpaid thirty (30) calendar days after the Member is given notice of delinquency and warned of the automatic suspension. If the Member still has not paid the required dues or assessments within six (6) months after such notice of delinquency, the Member's membership shall be automatically terminated.

6.8-5 PROFESSIONAL LIABILITY INSURANCE

If at any time a Member fails to maintain continuous professional liability insurance coverage (i.e., such coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect, in whole or in part) for all of the Member's Clinical Privileges, the Member's affected Clinical Privileges shall be suspended automatically as of that date until the Chief of Staff determines there is acceptable documentation of adequate professional liability insurance coverage, which shall include, unless excused by the Medical Executive Committee for good cause, "prior acts" coverage for the period of time during which the Member had allowed his or her coverage to lapse or become

noncompliant with Medical Staff requirements. If acceptable proof of such coverage is not provided to the Chief of Staff within ninety (90) days of such lapse, then the Member's Clinical Privileges and membership shall automatically terminate.

6.8-6 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENTS

Members are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence, providing requested information, and appearing at appropriately announced meetings regarding quality of care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs. It also includes submitting to mental or physician examinations, as requested by the Chief of Staff or the Medical Executive Committee, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's Privileges or related issues of reasonable accommodation. Failure to comply shall constitute grounds for Chief of Staff or a Department Chair to suspend the Member's Clinical Privileges or to take other appropriate action until a response is provided which is satisfactory to the requesting party. Any such suspension or action shall remain in effect until the Member is expressly notified that it is rescinded. For purposes of this Section, the information a Member can be expected to provide includes but is not limited to the following:

a. Physical or mental examinations and reports;

b. Information related to an investigation or other peer review action by another entity, including information concerning action taken by licensing or accreditation bodies and other healthcare entities;

c. Information from a Member's private office that is necessary to resolve questions that could have a bearing on the quality of care provided to patients in the Hospital; and

d. Information related to professional liability coverage and/or actions.

6.8-9 EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM

Whenever a practitioner is excluded from any Federal Health Care Program, the practitioner's Clinical Privileges shall be automatically suspended as of the effective date of such exclusion. Unless the Board of Directors determines, upon recommendation of the Medical Executive Committee, that the practitioner may still effectively practice at the hospital under such exclusion without creating unacceptable risk of penalty to the hospital or other Medical Staff members, unacceptable risk of disruption to hospital operations, or unacceptable publicity, the practitioner's Clinical Privileges and staff membership shall be terminated.

6.9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION FOLLOWING AUTOMATIC SUSPENSION OR LIMITATION

As soon as practicable after action is taken or warranted as described in Section 6.8, above, with the exception of routine suspensions for failure to complete medical records, the Medical

Executive Committee shall review and consider the facts related to the automatic suspension and may recommend further corrective action as it may deem appropriate.

6.10 PRACTITIONER OBLIGATIONS

Practitioners are responsible for complying with the limitations imposed by the provisions of Section 6.8 and shall immediately provide written notice to the Medical Staff office of any of the actions or events described therein; i.e. action taken by a state licensing agency, failure to maintain adequate insurance, action by the DEA, or action by a government funded health program. Whenever this occurs, the practitioner shall also promptly provide the Medical Staff Office with a written explanation of the basis for such actions, including copies of relevant documents. The limitations described above shall take effect automatically as of the date of the underlying action or event, regardless of whether the practitioner provides notice thereof to the Medical Staff Office. The Medical Executive Committee may request the practitioner to provide additional information concerning the above described actions or events, and a failure of the practitioner to provide such information may extend the special actions listed above, even though the underlying limitation may have been removed. A practitioner's failure to observe the limitations of Section 6.8 shall be grounds for corrective action.

ARTICLE VII

HEARINGS AND APPEALS

7.1 GENERAL PROVISIONS

7.1-1 INTENT:

The intent of these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as described below) and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Board of Directors from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board of Directors to create a hearing process which provides for the least burdensome level of formality in the process while still providing a fair review and to interpret these Bylaws in that light. The Medical Staff, Board of Directors, and their officers, committees and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

7.1-2 EXHAUSTION OF REMEDIES

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

7.1-3 INTRAORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly "judicial" rather than "legislative" in structure and function. The Hearing Committees have no authority to adopt new rules and standards, to modify existing rules and standards, or to resolve questions regarding the merits or substantive validity of Bylaws, Rules, Regulations or

policies. Challenges to the substantive validity of any Bylaw, Rule, Regulation or policy shall be handled according to Section 7.9-2 below.

7.1-4 DEFINITIONS

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

a. "Body whose decision prompted the hearing" refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Board of Directors in all cases where the Board of Directors or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.

b. "Practitioner" as used in this Article refers to the practitioner who may request or has requested a hearing pursuant to this Article.

c. "Day" means calendar day.

7.1-5 SUBSTANTIAL COMPLIANCE

Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or recommended by the bodies whose decisions prompted the hearing.

7.1-6 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

If the hearing is based upon an adverse action by the Board of Directors, the Chair of the Board of Directors shall fulfill the functions assigned in this Article to the Chief of Staff, and the Board of Directors shall fulfill the functions assigned in this Article to the Medical Executive Committee. The procedure may be modified as warranted under the circumstances, but the practitioner shall have all of the same rights to a fair hearing.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in applicable Bylaws, Rules, Regulations or policies, any one of the following adverse actions or recommended actions shall be deemed grounds for a hearing:

(a) Denial of Medical Staff membership, reappointment and/or Clinical Privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(b) Revocation of Medical Staff membership, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(c) Revocation or reduction of Clinical Privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(d) Significant restriction of Clinical Privileges (except for proctoring incidental to Provisional status, new privileges, insufficient activity, or return from leave of absence) for more than

fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

(e) Suspension of Medical Staff membership and/or Clinical Privileges for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients; and,

(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.

No actions or recommendations except those described above shall entitle the practitioner to request a hearing as described in this Article.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR RECOMMENDATION

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

a. A description of the action or recommendation;

b. A concise statement of the reasons for the action or recommendation;

c. A statement that the practitioner may request a hearing;

d. A statement of the time limit within which a hearing may be requested;

e. A summary of the practitioner's rights at a hearing; and

f. A statement as to whether the action or recommendation must be reported to California licensing authorities and/or the National Practitioner Data Bank.

7.3-2 REQUEST FOR HEARING

a. The practitioner shall have thirty (30) days following receipt of the notice of the action or recommendation within which to request a hearing. The request shall be in writing addressed to the Chief of Staff, and received by the Medical Staff Office within the deadline. A copy shall also be sent to the Chief Executive Officer. Executive Officer.

b. If 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. Said action shall thereupon become the final action of the Medical Staff. The action or recommendation shall be presented for consideration by the Board of Directors, which shall not be bound by it. If the Board of Directors ratifies the action or recommendation, it shall thereupon become the final action of the hospital. However, if the Board of Directors, after consulting with the Medical Executive Committee, is inclined to take action against the practitioner that is more

adverse than the action recommended by the Medical Staff, the practitioner shall be so notified and given and opportunity for a hearing based on "an adverse action by the Board of Directors" as provided herein.

7.4 HEARING PROCEDURE

7.4-1 TIME AND PLACE FOR A HEARING

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) days from the date he or she received the request for a hearing, give written notice to the practitioner of the time, place and date of the hearing. The date of commencement of the hearing shall be not less than thirty (30) days or more than sixty (60) days from the date the Chief of Staff received the request for hearing.

7.4-2 NOTICE OF REASONS OR CHARGES

Together with the notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse action taken or recommended (if not already provided), including a description of the acts or omissions with which the practitioner is charged and a list of the charts or cases in question, where applicable. The Notice of Reasons or Charges may be supplemented or amended at any time prior to the issuance of the Hearing Committee's decision, provided the practitioner is afforded a fair and reasonable opportunity to respond.

7.4-3 HEARING COMMITTEE

a. When a hearing is requested the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three (3) members of the Active Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders, or initial decision makers, and 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 Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the Active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories. Such appointment shall include, where feasible, at least one member who has the same healing arts licensure and practices in the same specialty as the Practitioner involved.

b. Alternatively, the Chief of Staff shall have the discretion to enter into an agreement with the practitioner involved to hold the hearing before a mutually acceptable arbitrator or arbitrators. Failure or refusal to exercise this discretion shall not constitute a breach of the Medical Staff's responsibility to provide a fair hearing.

c. A majority of the Hearing Committee must be present throughout the hearing. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent.

d. The Hearing Committee or the arbitrator (if one is used) shall have such powers as are necessary to discharge its or his or her responsibilities.

7.4-4 THE HEARING OFFICER

The Chief Executive Officer shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law who is qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the hospital or medical staff for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be biased for or against any party, 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 the 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 that are raised prior to, during, or after the hearing. If the Hearing Officer determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such action as he or she deems warranted by the circumstances. The Hearing Officer should participate in the deliberations of the Hearing Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

7.4-5 EXAMINATION (VOIR DIRE)

The practitioner shall have the right to a reasonable opportunity to examine (voir dire) the Hearing Committee members and the Hearing Officer, and the right to challenge the appointment of any member or the Hearing Officer. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include reasonable requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by the Hearing Officer. The Hearing Officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and Hearing Officers in proceedings of this type.

7.4-6 REPRESENTATION

a. The parties may be represented by legal counsel. However, the body whose decision prompted the hearing shall not be represented by an attorney at law if the practitioner is not so represented. The foregoing shall not be deemed to deprive any party of its right to be represented by legal counsel for the purpose of preparing for the hearing, including the identification and resolution of pre-hearing procedural issues or disputes. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a practitioner licensed in the State of California who is not also an attorney at law.

b. In all instances, whether or not attorneys are allowed to represent the parties during the hearing, the Medical Executive Committee shall be represented by a Member of the Medical Staff who shall be responsible for representing the Medical Executive Committee's interests in connection with the peer review matter and proceeding. This responsibility shall include the authority to make

decisions regarding the detailed contents of the Notice of Reasons or Charges; to make decisions regarding the presentation of testimony and exhibits; to direct the activities of the Medical Executive Committee's attorney, if any; to consult with specialists; and to amend the Notice of Reasons or Charges as he or she deems 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.

7.4-7 FAILURE TO APPEAR OR PROCEED; NON-COOPERATION OR DISRUPTION

Failure without good cause of the practitioner to personally attend and proceed at a hearing in an efficient and orderly manner, or serious or persistent misconduct or failure to cooperate in the hearing process by either party, shall be grounds for termination of the hearing as determined by the Hearing Committee in consultation with the Hearing Officer. Such conduct by the Practitioner shall be deemed to constitute a waiver of any hearing rights and voluntary acceptance of the recommendation(s) or action(s) involved. Such conduct by the Medical Executive Committee shall be deemed a failure to show that its action(s) or recommendation(s) are reasonable and warranted or, in the case of an initial application, a failure to present evidence in opposition to the application. The Hearing Committee's determination pursuant to this provision shall be presented for consideration by the Board of Directors, which shall exercise its independent judgment as to the appropriateness of the Hearing Committee's action in terminating the hearing.

7.4-8 POSTPONEMENTS AND EXTENSIONS

Once a timely request for a hearing has been made, postponements and extensions of the time beyond those referenced in this Article may be permitted by the Hearing Officer within his or her discretion.

7.5 DISCOVERY

7.5-1 RIGHTS OF INSPECTION AND COPYING

The Practitioner may inspect and copy, at his or her expense, any documentary information relevant to the charges that the Medical Executive Committee has in its possession or under its control. The Medical Executive Committee may inspect and copy, at its expense, any documentary information relevant to the charges that the Practitioner has in his or her possession or under his or her control. Requests for discovery shall be met as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

7.5-2 LIMITS ON DISCOVERY

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

7.5-3 RULING ON DISCOVERY DISPUTES

In ruling on discovery disputes, the factors that may be considered include:

a. whether the information sought may be introduced to support or to defend against the charges;

b. whether the information is "exculpatory" in that it would dispute or cast doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendation;

c. the burden imposed on the party in possession of the information sought, if access is granted, and

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

7.5-4 PREHEARING DOCUMENT EXCHANGE

The parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten (10) days prior to the hearing. Failure to comply with this rule is a good cause for the Hearing Officer to grant a continuance, or to limit the introduction of any documents not provided to the other party in a timely manner.

7.5-5 WITNESS LISTS

Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to provide the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

7.5-6 OBJECTIONS TO INTRODUCTION OF EVIDENCE PREVIOUSLY NOT PRODUCED FOR THE MEDICAL STAFF

The Medical Executive Committee may object to the introduction of evidence that was not provided during an appointment, reappointment or privilege application review, or during a corrective action investigation or process despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the Practitioner can prove he or she previously acted diligently and could not have submitted the information prior to the hearing.

7.6 MISCELLANEOUS PROCEDURAL MATTERS

7.6-1 PROCEDURAL DISPUTES

a. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as soon as possible in advance of the scheduled hearing, 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.

b. The parties shall be entitled to file motions or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the hearing record in a manner deemed appropriate by the Hearing Officer.

7.6-2 RECORD OF HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the prehearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the shorthand reporter shall be borne by the hospital, but the cost of preparing a transcript, if any, or a copy of a transcript that has already been prepared, shall be borne by the party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only under oath administered by a person lawfully authorized to administer such oath.

7.6-3 ATTENDANCE

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Hearing Officer, the following shall be permitted to attend the entire hearing in addition to the Hearing Officer, the court reporter, and the parties (with attorneys, if allowed): The Medical Staff Manager or Coordinator, one or more key consultants for each party, one or more key witnesses for each party, and the Chief Executive Officer or designee. An individual shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that he or she will be a witness for one of the parties.

7.6-4 RIGHTS OF THE PARTICIPANTS

Within reasonable limitations, both parties may call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents; cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available by the other party to the Hearing Committee; and submit a written statement, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may question witnesses or call additional witnesses if it deems such action appropriate. The Hearing Officer shall also have the discretion to ask questions of witnesses if he or she deems it appropriate for purposes of clarification or efficiency.

7.6-5 RULES OF EVIDENCE

Judicial rules of evidence and procedure relating to the conduct of a trial regarding the examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these provisions. Any relevant evidence, including hearsay, may be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a

court of law. Notwithstanding the foregoing, the content of any settlement discussions between the parties regarding the resolution of issues in the hearing shall not be admissible.

7.6-6 BURDENS OF PRESENTING EVIDENCE AND PROOF

a. The body whose decision prompted the hearing shall have the initial duty to present evidence which supports the recommendation or action. The Practitioner shall be obligated to present evidence in response.

b. An applicant for Membership and/or Privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is sufficiently qualified to be awarded such Membership and/or Privileges at this hospital. This burden requires the production of information which allows for adequate evaluation and resolution of reasonable doubts concerning the Practitioner's current qualifications. The applicant shall not be permitted to introduce information that was not produced upon the request of any committee or person on behalf of the Medical Staff during the application process, unless the Member establishes that the information could not have been produced in the exercise of reasonable diligence. This provision shall not be construed to compel the Medical Staff to act on, or to afford a Practitioner a hearing regarding, an incomplete application.

c. Except as provided above, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Hearing Committee. If the Hearing Committee finds, based on the evidence presented at the hearing, that the action being challenged is not within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, the Hearing Committee may recommend a different result, which may be either more adverse or less adverse to the Practitioner than the action that prompted the hearing.

7.6-7 ADJOURNMENT AND CONCLUSION

The Hearing Officer may adjourn and reconvene the hearing at such times and intervals as may be reasonable and warranted, with due regard for the objective of reaching an expeditious conclusion to the hearing.

7.6-8 BASIS FOR DECISION

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

7.6-9 DECISION OF THE HEARING COMMITTEE

Within thirty (30) days after the final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief of Staff, the Practitioner involved, and the Chief Executive Officer. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The decision shall include or be accompanied by a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or review as are described in these Bylaws.

7.7 APPEAL

7.7-1 TIME FOR APPEAL

a. Within ten (10) days after receipt of the decision of the Hearing 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 Executive Officer and the other party in the hearing. If a request for appellate review is not received by the Chief Executive Officer within such period, the decision of the Hearing Committee shall thereupon become final, except if modified or reversed by the Board of Directors.

b. It shall be the obligation of the party requesting appellate review to produce the record of the Hearing Committee's proceedings. If the record is not produced within a reasonable period, as determined by the Board of Directors or its authorized representative, appellate rights shall be deemed waived.

c. In the event of a waiver of appellate rights by a Practitioner, if the Board of Directors is inclined to take action which is more adverse than that taken or recommended by the Medical Executive Committee, the Board of Directors must consult with the Medical Executive Committee before taking such action. If after such consultation the Board of Directors is still inclined to take such action, then the Practitioner shall be so notified. The notice shall include a brief summary of the reasons for the Board's contemplated action, including a reference to any factual findings in the Hearing Committee's Decision that support the action. The Practitioner shall be given ten (10) days from receipt of that notice within which to request appellate review, notwithstanding his or her earlier waiver of appellate rights. The grounds for appeal and the appellate procedure shall be as described below. However, even If the Practitioner declines to appeal any of the Hearing Committee's factual findings, he or she shall still be given an opportunity to argue, in person and in writing, that the contemplated action which is more adverse than that taken or recommended by the Medical Executive Committee is not reasonable and warranted. The action taken by the Board of Directors after following this procedure shall be the final action of the Hospital.

7.7-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds of appeal, and a clear and concise statement of the facts in support of the appeal. The recognized grounds for appeal from a Hearing Committee decision are:

a. substantial noncompliance with the standards or procedures required by these Bylaws, or applicable law, which has created demonstrable prejudice; or

b. the factual findings of the Hearing Committee are not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to this section; or

c. the Hearing Committee's failure to sustain an action or recommendation of the Medical Executive Committee that, based on the Hearing Committee's factual findings, was reasonable and warranted.

7.7-3 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of a request for appellate review, schedule a review date and cause each side to be given notice of time, place and date of the appellate review. The appellate review shall not commence less than thirty (30) or more than sixty (60) days from the date of notice. The time for appellate review may be extended by the appeal board for good cause.

7.7-4 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) members of 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 action or recommendation being challenged. 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.

7.7-5 APPEAL PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the proceedings before the Hearing Committee. However, 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 Hearing Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation that are provided at a hearing. The appeal board shall also have the discretion to remand the matter to the Hearing Committee for the taking of further evidence or for clarification or reconsideration of the Hearing Committee's decision. In such instances, the Hearing Committee shall report back to the appeal board, within such reasonable time limits as the appeal board imposes. Each party shall have the right to be represented by legal counsel before the appeal board, to present a written argument to the appeal board, to personally appear and make oral argument and respond to questions in accordance with the procedure established by the appeal board. After the arguments have been submitted, the appeal board shall conduct its deliberations outside the presence of the parties and their representatives.

7.7-6 DECISION

Within thirty (30) days after the submission of arguments as provided above, the appeal board shall send a written recommendation to the Board of Directors. The appeal board may recommend, and the Board of Directors may decide, to affirm, reverse or modify the decision of the Hearing Committee. The decision of the Board shall constitute the final decision of the Hospital and shall become effective immediately upon notice to the parties. The parties shall be provided a copy of the appeal board's recommendation along with a copy of the Board of Director's final decision.

7.8 RIGHT TO ONE HEARING

No practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any adverse action or recommendation.

7.9 EXCEPTION TO HEARING RIGHTS

7.9-1 EXCLUSIVE CONTRACTS

The hearing rights described in this Article shall not apply as a result of a decision to close or continue closure of a department or service pursuant to an exclusive contract or to transfer an exclusive contract, or as a result of action by the holder of such an exclusive contract.

7.9-2 VALIDITY OF BYLAW, RULE, REGULATION OR POLICY

No hearing provided for in this article shall be utilized to make determinations as to the merits or substantive validity of any Medical Staff bylaw, rule, regulation or policy. Where a Practitioner is adversely affected by the application of a Medical Staff bylaw, rule, regulation or policy, the Practitioner's sole remedy is to seek review of such bylaw, rule, regulation or policy initially by the Medical Executive Committee. The Medical Executive Committee may in its discretion consider the request according to such procedures as it deems appropriate. If the Practitioner is dissatisfied with the action of the Medical Executive Committee, the Practitioner may request review by the Board of Directors, which shall have discretion whether to conduct a review according to such procedures as it deems appropriate. The Board of Directors shall consult with the Medical Executive Committee before taking such action regarding the bylaw, rule, regulation or policy involved. This procedure must be utilized prior to any legal action.

7.9-3 DEPARTMENT, SECTION OR SERVICE FORMATION OR ELIMINATION

A Medical Staff department, section, or service can be formed or eliminated only following a review and recommendation by the Medical Executive Committee regarding the appropriateness of the department, section, or service elimination or formation. The Board of Directors shall consider the recommendations of the Medical Executive Committee prior to making a final determination regarding the formation or elimination.

The Medical Staff Member(s) who's Privileges may be adversely affected by department, section, or service formation or elimination are not afforded hearing rights pursuant to Article VII.

ARTICLE VIII

OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer and Member-At -Large.

8.1-2 QUALIFICATIONS

Officers must be members of the Active Staff at the time of nomination and election, and must remain members in good standing during their terms of office. Failure to maintain that status shall immediately create a vacancy in the office involved. Only those members who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

(1) be members in good standing of the non-provisional Active Staff, and must remain members in good standing during their term of office. A "member in good standing" means the physician is not the subject of an adverse recommendation, as noted below:

(2) Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

(3) Not presently be serving as Medical Staff officers, Board members or chiefs at any other hospital and shall not so serve during their terms of office;

(4) Be willing to faithfully discharge the duties and responsibilities of the position;

(5) Have experience in a leadership position, or other involvement in performance improvement activities;

(6) Attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

(7) Have demonstrated an ability to work well with others.

8.1-3 NOMINATIONS

A. The Medical Staff shall provide for the election of the four (4) officers identified in Section 8.1-1, above, every two (2) years.

B. A Nominating Committee shall be convened, comprised of the Chief of Staff and two (2) other Active Staff members appointed by the Medical Executive Committee.

C. At least thirty (30) days prior to the deadline for voting as set forth in Section 8.1-4, below ("deadline for voting"), the Nominating Committee shall issue an announcement to the Medical Staff soliciting nominations for each office to be filled. Nominations may be submitted by any member of the Active Staff, and must be received by the Medical Staff Office at least fifteen (15) days prior to the deadline for voting.

D. After the close of nominations as provided above, the Nominating Committee will screen the nominees to confirm that they meet the qualifications for office in Article 8.1-2,. Each nominee will also be contacted to confirm his or her willingness to serve if elected. The

Nominating Committee will then apply the following criteria to determine, in its discretion, which nominees will appear on the ballot and for which offices:

(i) Balance of representation among specialties on the Medical Staff;
(ii) Avoidance of having more than three (3) candidates run for a given office;
(iii) Avoidance of having a single candidate run for more than one office;
(iv) The preference of the nominee regarding the office for which he or she will run, if nominated for more than one office; and
(v) Conflicting demands on the nominee if he or she is serving or has been elected to serve as Department Chair or Vice Chair.

E. In the event that the above process does not yield any qualified and willing candidates for a given office, or the Nominating Committee determines, in its discretion, that there should be one or more additional candidates for a given office, the Nominating Committee may nominate candidates on its own initiative and include them on the ballot.

F. Ballots will be issued at least five (5) days prior to the deadline for voting.

8.1-4 ELECTIONS

The election shall be by written or electronic ballot, and the outcome shall be determined by a majority of signed votes cast. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. Only members of the non-provisional Active Staff are eligible to vote in the election.

8.1-5 TERM OF ELECTED OFFICE

All officers shall serve a two (2) year term and shall take office on the first day of the Medical Staff year. At the end of that officer's term, the Chief of Staff shall automatically assume the office of the immediate Past Chief of Staff

An officer of the Medical Staff may be removed from office by a two-thirds vote of all Active Medical Staff members, for good cause, including but not limited to the following:
(a) neglect or misfeasance in office;
(b) serious acts of moral turpitude;
(c) failure to discharge satisfactorily the duties of office;
(d) failure of an officer to remain a member of the Active Medical Staff in good standing shall result in automatic removal from the medical staff office;
(e) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
(f) conduct detrimental to the interests of the hospital and/or its Medical Staff;
(g) an infirmity that renders the individual incapable of fulfilling the duties of that office;
(h) or loss of confidence and support of the Medical Staff.

To bring the matter to a vote, a motion must be made and seconded at a regular or special Medical Staff meeting or by a letter to the Medical Executive Committee requesting the removal of an officer. The letter must be signed by a minimum of three (3) members of the Active Medical Staff. If a vote affirming the removal of an officer is obtained, the officer will immediately relinquish his/her position.

At least ten 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 Executive Committee prior to a vote on removal.

8.1-6 VACANCIES IN ELECTED OFFICE

Vacancies of the Secretary/Treasurer during the Medical Staff year shall be filled by the Medical Executive Committee. If there is a vacancy in the Office of the Chief of Staff, the Vice Chief of Staff shall serve for the remainder of his/her term. Should the Vice Chief of Staff be elevated to fill the Chief of Staff position, a special election shall be held to fill the Vice Chief of Staff position. In the event there is a vacancy in the Office of the Vice Chief of Staff, the Executive Committee shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the Executive Committee.

8.2 ADMINISTRATIVE COVERAGE

When a Medical Staff, quality, or peer review issue or event needs immediate attention, in the absence of the Chief of Staff, the following representatives, in the order of succession, shall have all the powers of and be subject to all the restrictions upon the Chief of Staff, as defined in these Bylaws:

(1) Vice Chief of Staff, or
(2) Immediate Past Chief of Staff;
(3) Secretary/Treasurer;
(4) Member-At-Large;
(5) Appropriate Chief of Service or Chairman;
(6) Hospital CEO

8.2 DUTIES AND AUTHORITY OF OFFICERS

8.2-1 CHIEF OF STAFF

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

a. enforcing the Medical Staff Bylaws and Rules, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

b. exercising such authority as he/she deems necessary so that at all times patient welfare takes precedence over all other concerns;

c. in the interim between Medical Executive Committee meetings, performing those responsibilities of the Committee that, in his/her opinion, must be accomplished prior to the next regular or special meeting of the Committee;

d. calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

e. serving with a vote as Chair of the Medical Executive Committee;

f. serving as an ex officio member of all other Medical Staff committees without vote, unless his/her membership in a particular committee is required by these Bylaws, in which case voting rights shall apply unless otherwise specified;

g. interacting with the Chief Executive Officer and the Board of Directors in all matters of mutual concern within the Hospital;

h. appointing, with the agreement of the Medical Executive Committee, committee members and chair persons for all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairperson of these committees with the approval of the Medical Executive Committee;

i. representing the views and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer;

j. being a spokesman for the Medical Staff in external professional and public relations;

k. performing such other functions as may be assigned to the Chief of Staff by these Bylaws or the Rules, or by the Medical Executive Committee;

l. serving on liaison committees with the Board of Directors and Hospital Administration, as well as outside licensing or accreditation agencies; and,

m. being the designated person who receives reports or concerns on physician impairment.

n. continue to serve on the Medical Executive Committee, as the Past Chief of Staff, immediately following the election term for as much time as needed to assure continuity in the transition with the change in leadership.

8.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff is the second officer of the Medical Staff. The Vice Chief of Staff shall serve for two years and assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a voting member of the Medical Executive Committee and of the Joint Conference Committee, and shall perform

such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee. The Vice Chief of Staff shall be a member of the Quality Assessment Committee. The Vice Chief of Staff will remain on the Medical Executive Committee and serve until the next Vice Chief of Staff has been elected.

8.2-3 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and a member of the Joint Conference Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by the Bylaws, or by the Medical Executive Committee. The Immediate Past Chief of Staff will remain on the Medical Executive Committee for at least three (3) months to assure a smooth transition with the change in leadership and longer as deemed necessary

8.2-4 SECRETARY-TREASURER

The Secretary-Treasurer is the third officer of the Medical Staff. The Secretary-Treasurer shall be a voting member of the Medical Executive Committee. His/her duties shall include, but not be limited to:

a. maintaining a roster of Medical Staff members;
b. keeping accurate and complete minutes of all Medical Executive Committee and general and special Medical Staff meetings;
c. calling meetings on the order of the Chief of Staff or Medical Executive Committee;
d. attending to all appropriate correspondence and notices on behalf of the Medical Staff;
e. receiving and safeguarding all funds of the Medical Staff including operational and scholarship funds and presenting financial reports to the Medical Executive Committee;
f. serving on any committee as assigned; and,
g. performing such other duties as ordinarily pertains to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

8.2-5 MEMBER-AT-LARGE

a. Serves as chairman of the Ethics Committee.
~~a.~~b. Perform such other functions as may be assigned by the Chief of Staff or Medical Executive Committee.

ARTICLE IX

CLINICAL DEPARTMENTS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 9.5 of these Bylaws. A department may be further divided, as appropriate, into different clinical services. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination,

modification, or combination of departments. Three or more physicians on the Active Staff are required to organize a separate department.

9.2 CURRENT DEPARTMENTS

The current departments are: Anesthesia, Medicine, Surgery, Obstetrics-Pediatrics, and Emergency Medical Care.

(a) The Department of Medicine shall include the clinical services of internal medicine, mental health, family practice, diagnostic imaging, gastroenterology, and medical subspecialties.

(b) The Department of Surgery shall include the clinical services of general surgery, orthopedics, gynecology, otolaryngology, ophthalmology, urology, vascular surgery, general dentistry, pathology, plastic and reconstructive surgery, and podiatry.

(c) The Department of Obstetrics and Pediatrics shall include the clinical services of obstetrics and pediatrics.

(d) The Department of Emergency Medical Care shall include the clinical service of emergency medicine.

(e) The Department of Anesthesia shall include the clinical service of anesthesia.

9.3 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned membership in at least one department.

9.4 FUNCTIONS OF DEPARTMENTS

Each department, functioning as a committee of the whole, is responsible for the quality of care within the Department, and for the effective performance of the following:

(a) conducting patient care reviews and utilization review through analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department with the purpose of improving care. The manner of patient care review will be outlined in the Quality Assessment Plan, and shall be approved by the Medical Staff;

(b) recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the Department;

(c) conducting, participating, and making recommendations regarding educational programs pertinent to Departmental clinical practice;

(d) reviewing and evaluating Departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

(e) coordinating patient care provided by the Department's members with nursing and ancillary patient care services;

(f) submitting written reports to the Medical Executive Committee concerning: (1) the Department's review and evaluation activities, actions taken thereon, and the results of

such action; (2) recommendations for maintaining and improving the quality of care provided in the Department and the Hospital; and (3) how quality and utilization review functions will be addressed;

(g) meeting regularly for the purpose of considering patient care review findings and the result of the Department's other review and evaluation activities, as well as reports on other Department and Medical Staff functions;

(h) establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

(i) taking appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

(j) accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Department;

(k) formulating recommendations for Departmental Rules reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical Staff; and

(l) Recommending space and other resources needed by the Department; and assessing and recommending off-site sources for needed patient care, treatment and services within the purview of, but not provided directly by the Department.

9.5 DEPARTMENT CHAIR AND VICE CHAIR

9.5-1 QUALIFICATIONS

Each department shall have a chair and vice chair who shall be a member of the Active Medical Staff and ~~shall, if required by law, be board certified or board qualified in his/her specialty, or possess comparable qualifications and competence; and, further,~~ shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department. Demonstrated ability may be shown through certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process. Attendance at relevant educational conferences, previous service as a Department Chief, or other prior active participation in Department and Medical Staff affairs are also relevant factors.

9.5-2 SELECTION

The chair and vice chair shall be elected by those members of the Department who are eligible to vote for general officers of the Medical Staff. ~~Nominations shall be made from the floor when the election meeting is held.~~In the fall of every other year but no later than the end of November, each Department shall select its chief. If the Department fails to do so, the Chief of Staff shall appoint the Department 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.

9.5-3 TERMS OF OFFICE

Each department chair and vice chair shall serve a two (2) year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or privileges in that department. Department chairs shall be eligible, without further vote, to succeed themselves. The intention is for the Vice Chair to assume the role as chair for the following term, if elected.

9.5-4 REMOVAL

Department chairs and vice chairs may be removed from office for valid cause, including, but not limited to, to loss of confidence and support of the members of the Department, failure to cooperatively and effectively perform the responsibilities of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude. Removal of a department chair may be initiated by the Medical Executive Committee or by a petition which states the grounds for removal and is signed by at least one-third of the members of the department eligible to vote. Removal shall be considered at a special meeting called for that purpose. The grounds for the proposed removal shall be presented to the chair or vice chair in writing at least seven (7) days prior to the special meeting, and the chair or vice chair shall be given the opportunity to address the stated grounds before the matter is put to a vote. Removal shall require a two-thirds vote of department members eligible to vote on Department matters, voting either in person at the special meeting or by mail ballot.

9.5-5 DUTIES OF DEPARTMENT CHAIR

Each Department chair shall have the following authority, duties and responsibilities:

a. act as presiding officer at departmental meetings;

b. report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the Department;

c. evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that Department;

d. generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the Department through a planned and systematic process; and oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the Medical Executive Committee. At the discretion of the chair, this function may be delegated to the vice chair;

e. develop and implement Departmental programs for retrospective patient care review, on-going monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment;

f. be a voting member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the Department;

g. transmit to the Medical Executive Committee the Department's recommendations concerning practitioner appointment and classification,

reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the Department;

h. endeavor to enforce the Medical Staff Bylaws, Rules, and policies within the Department;

i. communicate and implement within the Department actions taken by the Medical Executive Committee;

j. participate in every phase of administration of the Department, including making recommendations for space and other resources needed by the Department and cooperating with the nursing service and the Hospital Administration in matters such as personnel, supplies, special regulations, standing orders, and techniques;

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

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

9.5-6 DUTIES OF DEPARTMENT VICE CHAIR

The vice chair shall assume all duties and authority of the chair in the absence of the chair. The vice chair will be the Department representative to the Infection Control and Pharmacy and Therapeutics Committees. . The intention is for the Vice Chair to assume the role as chair for the following term, if elected.

ARTICLE X

COMMITTEES

10.1 DESIGNATION

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or a department to perform specified tasks. The purpose of Medical Staff committees shall be to monitor and improve the quality of patient care services and perform other functions related to the needs of the Medical Staff, the hospital, or applicable standards and legal requirements. Any committee, whether Medical Staff-wide or department or other clinical unit, or standing or ad hoc, including the Medical Staff meeting as a committee of the whole, 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.

10.2 GENERAL PROVISIONS

10.2-1 APPOINTMENT OF MEMBERS

a. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee.

b. A Medical Staff committee shall be composed as stated in the description of the

committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws or Rules, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members, allied health professionals, representatives from Hospital departments such as administration, nursing services, or health information services; representatives of the community, and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with vote unless the statement of committee composition designates the position as non-voting. Unless otherwise specified in these bylaws, all non-Medical Staff members appointed to committees shall be nonvoting. When non-physician members have been granted a vote on a Medical Staff committee, such voting rights shall only be exercised relative to the practitioner's area of clinical expertise and restricted by the practitioner's scope of licensure. The Chief of Staff shall be a nonvoting, ex-officio member on all committees to which he/she is not otherwise specifically assigned.

c. The committee chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.

d. Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his/her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

10.2-2 TERMS OF COMMITTEE MEMBERS

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

10.2-3 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of privileges, or if any other good cause exists, that member may be removed by the Chief of Staff with the approval of the Medical Executive Committee.

10.2-4 VACANCIES

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

10.2-5 ACCOUNTABILITY

All committees shall be accountable to the Medical Executive Committee.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

a. The officers of the Medical Staff;

b. The Department chairs;

c. The Medical DirectorChairman of Quality;

c.d. The Chairman of Ethics Committee;

d.e. The Incline Village Community Hospital Committee Chair; and,

e. The Diagnostic Imaging Committee Chair; and,

f. Medical Director of Innovation and Strategic Planning

g.f. The Chief Executive Officer, the Chief Operating Officer, the Chief Nursing Officer, the Director of Quality, the Director of Nursing and Operations for Incline Village Community Hospital the Chief Medical Officer, and a member of the IDPC representing Allied Health Professionals, who may attend on an ex-officio basis without a vote.

10.3-2 DELEGATION OF AUTHORITY

By adopting these Bylaws, the Medical Staff has delegated to the Medical Executive Committee the authority to perform on behalf of the Medical Staff the duties and functions described in these Bylaws, specifically including those described in this Section 10.3 and in Articles XIII and XIV. Such delegation can be limited or removed only by amendment of these Bylaws.

10.3-3 DUTIES

The duties of the Medical Executive Committee shall include, but not be limited to:

a. serving as the governing body of the Medical Staff, which shall include representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

b. coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

c. receiving and acting upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups;

d. recommending actions to the Board of Directors on matters of a medical-administrative nature;

e. recommending the organizational structure of the Medical Staff, the mechanism to review credentials, delineate individual clinical privileges, restrict or terminate privileges or membership and provide fair hearings, the organization of quality assessment activities and mechanisms of the Medical Staff, as well as other matters relevant to the operation of an organized Medical Staff;

f. evaluating the medical care rendered to patients in the Hospital as necessary to assure that all patients admitted or treated in any of the Hospital services receive a uniform standard of quality patient care, treatment, and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances;

g. participating in the development and approval of all Medical Staff and Hospital policies, practice, and planning;

h. reviewing the qualifications, credentials, performance and professional competence and character of applicants for both clinical privileges and/or Medical Staff membership, obtaining and considering the recommendations of the concerned departments, and making recommendations to the Board of Directors regarding Medical Staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

i. taking reasonable steps to promote ethical conduct and quality clinical performance on the part of all those requesting or holding clinical privileges and all members including requiring evaluation of performance whenever there is doubt about a practitioner's ability to perform requested privileges and/or the initiation of and participation in Medical Staff corrective or review measures when warranted;

j. taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

k. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;

l. reporting to the Medical Staff at each regular Medical Staff meeting;

m. assisting in the obtaining and maintenance of accreditation for the hospital and any related components;

n. developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

o. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

p. reviewing the quality and appropriateness of services provided by physicians and allied health professionals enjoying agreements with the Hospital;

q. reviewing and approving the designation of the Hospital's Authorized Representative for National Practitioner Data Bank purposes; and

r. reviewing and approving the Utilization Review and Quality Assessment Plans; and

s. initiating, approving, and/or recommending to the Board of Directors, Medical Staff Bylaws, Rules and Regulations, and Policies, and amendments and technical corrections thereto, in accordance with Articles XIII and XIV of these Bylaws.

10.3-4 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least once a month and shall maintain a record of its proceedings and actions.

10.3-5 REMOVAL OF MEDICAL EXECUTIVE COMMITTEE MEMBERS

Medical Staff Officers and Department Chairs shall be removed from the Medical Executive Committee following removal from their respective positions as provided for in the relevant provisions of these Bylaws.

All other members of the Committee may be removed for valid cause, including but not limited to substantial neglect or misfeasance or other failure to discharge satisfactorily the duties of a Medical Executive Committee member, according to the following procedures:

a. Proceedings to remove the member may be initiated by the Medical Executive Committee or by a petition signed by at least 25% of the Medical Staff members eligible to vote for Medical Staff officers.

b. Once initiated, removal shall be considered at a regular or special meeting of the Medical Staff.

c. The grounds for removal shall be presented in writing by the Chief of Staff to the member whose removal has been proposed, at least ten (10) days before the Medical Staff meeting at which the matter will be put to a vote.

d. The member shall be given an opportunity to make a statement at the meeting regarding the asserted grounds for removal, prior to the vote. The Chief of Staff has discretion to determine whether a representative of the Medical Executive Committee or other group of Medical Staff members who proposed removal also should be given an opportunity to speak prior to the vote. The Chief of Staff may establish a reasonable time limit for any such statements.

e. Voting shall be by secret ballot marked "for" or "against" removal. The member will be removed from the Medical Executive Committee if a majority of the eligible members who cast ballots at the meeting vote "for" removal.

10.4 JOINT CONFERENCE COMMITTEE

Except as otherwise provided in Section 13.11 of these Bylaws, with respect to any conflict between the Medical Staff and the Board of Directors, the Medical Staff and Board shall meet and confer in good faith to resolve the dispute. Unless otherwise agreed, the forum for this shall be a committee composed as specified below; however, the Medical Staff and Board can utilize additional or different forums or processes, such as mediation, so long as both the Medical Staff and Board mutually agree to the forum or process as well as any procedures that would govern the process.

10.4-1 COMPOSITION

The Joint Conference Committee shall consist of the Chief of Staff, the Vice-Chief of Staff, the immediate past Chief of Staff, the Chief Executive Officer, and two (2) members of the Board of Directors appointed by the President of the Board. The Chair shall alternate at the beginning of the Medical Staff year between a Medical Staff JCC member selected by the Chief of Staff and a Board of Directors JCC member.

10.4-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and a forum for 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 exercise other responsibilities set forth in these Bylaws or in the bylaws of the Hospital.

10.4-3 EXHAUSTION

Prior to seeking judicial relief over any dispute with the Hospital or Board of Directors, including any allegation that the Hospital or Board has engaged in, or is about to engage in, acts or practices that hinder, restrict or obstruct the Medical Staff's ability to exercise its rights, obligations or responsibilities, the Medical Staff must first make a reasonable effort to resolve the dispute, including the pursuit of the administrative remedies provided in these Bylaws.

10.4-4 MEETINGS

The Joint Conference Committee shall meet as often as necessary and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Directors.

ARTICLE XI

MEETINGS

11.1 MEETINGS

11.1-1 ANNUAL MEETING

a. There shall be an Annual Meeting of the Medical Staff in ~~December~~ November of each year. Notice of this meeting shall be given to the members at least thirty (30) days prior to the meeting.

b. The Chief of Staff, or such other officers, Department chairs, or committee chairs as designated, may present reports on actions taken during the preceding year and on other matters of interest and importance to the members.

c. Announcement of the results of the election of officers shall occur at this meeting.

11.1-2 REGULAR GENERAL MEDICAL STAFF MEETINGS

Regular meetings of the Medical Staff may be held each quarter, except that the Annual Meeting shall constitute the regular meeting during the quarter in which it occurs. 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.

11.1-3 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 not fewer than ten percent (10%) of the Active Medical Staff. The request for the special meeting shall state the purpose of the proposed meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or

delivered to the members of the Medical Staff, which includes the stated purpose of the meeting.

11.2 COMMITTEE AND DEPARTMENT MEETINGS

11.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the committees as a whole, the chairs of committees, and Departments as a whole may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the members are given adequate notice of meeting dates. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

11.2-2 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, or be called by written request of ten percent (10%) of the current members, eligible to vote, but no fewer than 2 members.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The presence of twenty-five (25%) percent of the total membership of the Active Medical Staff at any regular or special meeting in person or by proxy shall constitute a quorum.

11.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of one-half of the voting members shall be required for Medical Executive Committee meetings. For other committees and for Departmental meetings, a quorum shall consist of not less than two voting members.

11.4 MANNER OF ACTION

Except as otherwise specified, the action of the 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 meetings, or such greater number as specifically required by these Bylaws. Committee or Department action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee or Department if it is acknowledged in writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

11.5 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. A copy of the minutes shall be provided tow the presiding officer of the meeting and forwarded to the Medical Executive Committee. The Medical Staff Office shall maintain those minutes.

11.6 ATTENDANCE REQUIREMENTS

11.6-1 REGULAR ATTENDANCE

Except as stated below, each member of the Active and Courtesy Staff shall be encouraged to attend the Annual Medical Staff meeting and required to attend at least fifty percent (50%) of all meetings of each Department (Active Staff) and committee of which he/she is a member. Active Staff members shall be required to attend at least 50% (two meetings per year) of regular General Medical Staff meetings each year.

Each member of the Courtesy Staff shall be required to attend such other meetings as may be determined by the Medical Executive Committee.

Failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action, pursuant to these Bylaws, ~~up to and including revocation of Medical Staff membership~~.

11.6-2 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. The request 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 subject involved. Failure of a member to appear at any meeting, with respect to which he/she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for action pursuant to Section 6.4-3.

ARTICLE XII

CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Medical Staff membership or privileges within this Hospital, an applicant:

a. authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon 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 the Bylaws and to waive to the fullest extent permitted by law all legal claims against any representative of the Medical Staff or the Hospital or any third party who acts in accordance with the provisions of this Article and the Bylaws and Rules; and

d. acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership and privileges, the continuation of that membership, and to the exercise of privileges at this Hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 GENERAL

Minutes, files, records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff when meeting as a committee of the whole, meetings of Departments, meetings of committees established under the Bylaws, and meetings of special or ad hoc committees created under the Bylaws, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential and protected by applicable state and/or federal peer review confidentiality laws, including but not limited to California Evidence Code Section 1157 and Nevada Rev. Stat. Sections 49.119-121 and 49.265. These records and information shall become a part of the Medical Staff committee files and shall not become part of any patient files, of general Hospital records, or of any member's personal or office files.

Access to such records for Medical Staff purposes shall be limited to duly appointed officers and committees of the Medical Staff as necessary to discharge medical staff responsibilities and subject to the requirements that confidentiality is maintained. By serving on a department, Medical Staff or Hospital committee, a Medical Staff member pledges that he or she will not waive the confidentiality respecting any committee on which he or she serves, except as expressly required by law.

12.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment must be based on free and candid discussions, any breach of confidentiality of the discussion or deliberations of the Medical Staff Departments, or committees, except as authorized, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Staff or Hospital may undertake such corrective action as is deemed appropriate.

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

Each representative, agent, member, and employee of the Medical Staff and Hospital shall be immune, to the fullest extent permitted by law, from liability to any individual who at any time was an applicant to or member of the Medical Staff, or who did or does exercise clinical privileges or provide services at the Hospital, for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

12.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to any individual who at any time was an applicant to or member of the Medical Staff, or who did or does exercise clinical privileges or provide services at the Hospital, for damages or other relief by reason of providing information concerning such person.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4-1 ACTIVITIES

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

a. application for appointment, reappointment, clinical privileges, or specified services;

b. periodic reappraisals for reappointment, clinical privileges, or specified services;

c. corrective action and peer review;

d. hearings and appellate reviews;

e. utilization review and quality assessment, including patient care audits and morbidity and mortality reviews;

f. other Department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

g. the actions of peer review organizations, state medical boards, and other entities which engage in monitoring or evaluation of professional competence or conduct, including queries and reports to or from the National Practitioner Data Bank, Medical Board of California, Nevada State Board of Medical Examiners, specialty boards, peer review organizations and other professional or health care related entities.

12.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.6 CUMULATIVE EFFECT

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

12.7 ACCESS TO MEDICAL STAFF FILES BY PERSONS WITHIN THE HOSPITAL OR MEDICAL STAFF

12.7-1 MEANS OF ACCESS

Unless otherwise stated, a person permitted access under this section shall be given reasonable opportunity to inspect the records in question and to make notes regarding them, but not to remove them or to make copies of them. Removal or copying shall be only upon the express written permission of the Medical Executive Committee.

12.7-2 PERSONS GAINING ACCESS

a. **Chief Executive Officer or Designated Representative**. The Chief Executive Officer or his/her designated representative shall have access to all Medical Staff records.

b. **Medical Staff Department Members**. The Medical Staff Department chairs and other members of the Department to the extent that they are involved in a credentialing or peer review process conducted pursuant to the Medical Staff Bylaws shall have access to the files of the Department committee on which they serve and the credentials and peer review files of practitioners under evaluation.

c. **Officers of the Medical Staff**. Officers of the Medical Staff and others carrying out official Medical Staff duties and responsibilities as provided in these Bylaws (including members of ad hoc investigative committees) shall have access to credentials and peer review files as necessary to carry out their duties and responsibilities.

12.7-3 GENERAL ACCESS BY PRACTITIONERS TO MEDICAL STAFF RECORDS

a. **Credentials and Peer Review Files**. Upon request, a practitioner shall be afforded a copy of any document in the credentialing and any peer review file concerning him/her if the document was submitted by him/her (for example, an application for Medical Staff membership or correspondence) or if the document was addressed to him/her or if its author had provided a "cc" to him/her. At the discretion of the Chief of Staff, a summary of some or all other information in these files may be provided to the practitioner.

b. **Medical Staff Committee and Department Files**. A practitioner shall have access to Medical Staff committee and Department files regarding him/her only if, following a written request by the practitioner, the Medical Executive Committee grants permission upon a showing of good cause.

12.8 ACCESS BY PERSONS OR ORGANIZATIONS OUTSIDE OF THE HOSPITAL OR MEDICAL STAFF

12.8-1 CREDENTIALING OR PEER REVIEW AT OTHER HOSPITALS

Any request for credentialing or peer review information by another institution should be presented in writing. No information shall be released until a copy of an acceptable release signed by the subject practitioner has been received from the requesting institution.

12.8-2 OTHER REQUESTS

All other requests by persons or organizations outside of the Hospital for information contained in the Medical Staff records shall be forwarded to the Chief Executive Officer. Any such request shall be in writing and shall be accompanied by a release signed by the concerned practitioner. The release of any such information shall require the concurrence of the Chief of Staff and the Chief Executive Officer.

12.8-3 SUBPOENAS AND REQUESTS FROM GOVERNMENT AGENCIES

All subpoenas and requests from government agencies for Medical Staff records shall be referred to the Chief Executive Officer. The Medical Staff Office, the Risk Manager and the Chief of Staff shall be informed of the subpoena. No documents or records will be released without consultation with the Chief of Staff, or his/her designee

12.9 RESPONSIBILITIES OF MEMBERS OF THE MEDICAL STAFF

Recognizing the importance of preserving the confidentiality of information, all individuals covered by this policy agree to respect the confidentiality of all information obtained in connection with their responsibilities. This requirement of confidentiality extends not only to the information contained in the physical files of the Medical Staff, but to the discussions and deliberations of Medical Staff committees.

12.10. INSERTION, DELETION, AND/OR CHANGES TO MEDICAL STAFF MEMBERS' CREDENTIALS FILE

12.10-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member's credentials file:

a. Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members.

b. When a request is made for insertion of adverse information into the Medical Staff member's credentials file, the respective Department chair and Chief of Staff shall review such a request.

c. After such a review, a decision will be made by the respective Department chair and Chief of Staff to:

   i. not insert the information;
   ii. notify the member of the adverse information by a written summary, and offer him/her the opportunity to rebut this assertion before it is entered into his/her file; or

   iii. notify the member of the adverse information, and insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation.

d. This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

12.10-2 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION, DELETION, OR ADDITIONS TO FILE

a. When a member has reviewed his/her file as provided in accordance with Medical Staff policy and these Rules, he/she may address to the Chief of Staff a written request for correction or deletion of information in his/her credentials file. Such a request shall include a statement of the basis for the action requested.

b. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or

not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

c. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

d. In any case, a member shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

ARTICLE XIII

GENERAL PROVISIONS

13.1 RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES

Subject to approval by the Board of Directors, the Medical Executive Committee may supplement these Bylaws with Rules and Regulations or Policies that provide associated details, as it deems necessary to implement more specifically the general principles established in these Bylaws. Rules and Regulations and Policies shall become effective upon approval by the Board, which shall not be withheld unreasonably. Neither the Medical Staff nor the Board may unilaterally amend the Rules and Regulations or Policies.

Proposals for new Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

The Medical Staff Bylaws, Rules and Regulations, and Policies shall not conflict with the Board Bylaws.

13.1-1 PROPOSALS BY THE MEDICAL EXECUTIVE COMMITTEE

a. The Medical Executive Committee shall initiate and adopt such general Rules and Regulations as it may deem necessary for the proper conduct of the Medical Staff's affairs and shall periodically review and revise the Rules and Regulations to comply with current Medical Staff practice. Additions or recommended changes to the general Medical Staff Rules and Regulations shall be generated by or submitted to the Medical Executive Committee for review and approval.

b. Any new or amended provisions for the Rules and Regulations proposed by the Medical Executive Committee shall be announced to the Medical Staff, which shall be afforded a period of at least thirty (30) days to submit written comments for consideration by the Medical Executive Committee before the provisions are submitted to the Board of Directors. Notice of the proposed provisions to the Medical Staff shall be in a reasonable manner, which may include posting in a newsletter or bulletin, distribution at a general Medical Staff meeting, or any other method regularly used by the Medical Staff Office to provide notices to members. The Medical Executive Committee may retain, modify or abandon the provisions, as it deems appropriate in light of the comments, if any. Notice of

new or amended Policies adopted by the Medical Executive Committee shall be provided to the Medical Staff promptly upon approval by the Board of Directors.

13.1-2 PROPOSALS BY PETITION

Proposals for new Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

a. A proposal bearing the signatures of 25% or more of the voting members of the Active Medical Staff (which will constitute notice of the proposal to the Medical Executive Committee) must identify two Active Medical Staff members who will serve as representatives and act on behalf of the proposal signers in the processes described below (including any conflict management processes):

b. If the Medical Executive Committee supports a proposed amendment of the Rules and Regulations as submitted, the proposal will be disseminated to the Medical Staff for comment as described in Section 13.1-1 above, before the Medical Executive Committee submits the proposal to the Board of Directors for approval. The Medical Executive Committee is not required to submit proposed Policies or proposed Policy amendments to the Medical Staff for comment.

c. If the Medical Executive Committee does not support the proposal, it will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 13.12 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposal will be deemed withdrawn.

d. If the conflict is not resolved by withdrawal of the proposal, or by Medical Executive Committee support of the proposal as modified in the conflict management process, then the proposal will be submitted (in original form or, if the original proposal has been modified in the conflict management process, then as modified) to the Medical Staff for comment as described below before the proposal is submitted to the Board of Directors for approval.

e. With respect to any Rules and Regulations proposal that does not bear the signatures of 25% of Active Medical Staff members, the Medical Executive Committee has discretion to do any of the following:

- disseminate the proposal, as submitted, to the Medical Staff for comment;
- modify the proposal and disseminate it, as modified, to the Medical Staff for comment; or
- reject the proposal and not disseminate it to the Medical Staff for consideration.

f. With respect to any Policy proposal that does not bear the signatures of 25% of Active Medical Staff members, the Medical Executive Committee may accept, modify or reject the proposal without disseminating it to the Medical Staff for comment.

g. Except as otherwise provided in this Article, before the Medical Executive Committee submits any proposal for adoption or amendment of Rules and Regulations to the Community Board for approval, the Medical Executive Committee shall disseminate the proposal to the Medical Staff, as described in Section 13.1-1 above. Members of the Medical Staff shall be given an opportunity to submit written comments, through the Medical Staff Office, for a period of not less than thirty (30) days.

h. After considering any comments that have been received within the allotted period, the Medical Executive Committee may modify the proposal in light of the comments. The Medical Executive Committee will disseminate any such modified proposal to the Medical Staff, and may, in the Medical Executive Committee's discretion, solicit further comments in the manner described above.

i. If a proposal did not include the signatures of 25% or more of the voting members of the Active Medical Staff, but the Medical Executive Committee disseminated the proposal to the Medical Staff for comment, then after the comment period ends the Medical Executive Committee in its discretion may do either of the following:

- submit the proposal to the Board of Directors for approval, in its original form or as modified in light of the comments; or
- reject the proposal and not submit it to the Community Board.

13.1-3 DEPARTMENT RULES AND REGULATIONS AND POLICIES

Rules and Regulations and Policies for Medical Staff Departments may be established and amended by the same process as general Medical Staff Rules and Regulations and Policies, except that:

a. Department-initiated proposals for establishing or amending Department-specific Rules and Regulations or Policies shall be submitted to the Medical Executive Committee by the relevant Department Chair following adoption by a majority of the voting members of the Department.

b. Department-initiated proposals that are acceptable to the Medical Executive Committee as submitted may be adopted by the Medical Executive Committee and submitted to the Board of Directors for approval.

c. Each Medical Executive Committee-initiated proposal and Department-initiated proposal that the Medical Executive Committee proposes to modify or reject shall be disseminated for comment to the relevant Department, along with a statement of the Medical Executive Committee's reasons, before the Medical Executive Committee submits any such proposal to the Board of Directors for approval. The Department will have 30 days to submit responsive comments to the Medical Executive Committee in writing, and any such Department comments will be submitted to the Board along with the Medical Executive Committee's proposal.

d. If the Medical Executive Committee has rejected a Department-initiated proposal, the Department Chair (or another Department representative chosen by the Department members, if the Chair does not support the proposal) may invoke the conflict management process set forth in Section 13, 12 of these

Bylaws within 30 days of receiving notice of the rejection. If the conflict management process is not invoked timely, it will be deemed waived. If the matter is not resolved in the conflict management process, the proposal will be submitted to the Board of Directors for approval along with the written comments of the Department and the Medical Executive Committee.

e. If the Board of Directors does not approve a Department-specific proposal, the Medical Executive Committee, Department Chair, and/or designated Department representative may invoke the conflict management process set forth in Section 13.11 of these Bylaws within 30 days of receiving notice of that the Board did not approve the proposal.

13.1-4 URGENT NEED

a. If the Medical Executive Committee receives documentation of an urgent need to amend the Medical Staff Rules and Regulations to comply with law or regulation, the Medical Executive Committee may adopt the necessary amendment provisionally and submit it to the Board of Directors for provisional approval, without prior notification of the Medical Staff. Immediately following the Medical Executive Committee's adoption of such an urgent provisional amendment to the Rules and Regulations, the Medical Executive Committee will notify the Medical Staff (by an acceptable method of providing such notice as described above), and offer an opportunity for any interested Medical Staff member to submit written comments to the Medical Executive Committee within 30 days of the date of the notice. The amendment will become final at the end of the comment period if the comments indicate there is no substantial conflict regarding the provisional amendment. There is no substantial conflict unless at least 25% of voting Active Medical Staff members expresses opposition to the amendment in writing.

b. If the comments indicate a substantial conflict over the provisional amendment, then the Medical Executive Committee will implement the conflict management process set forth in Section 13.12 of these Bylaws, and may submit a revised amendment to the Board for approval if necessary.

13.1-5 ADOPTION BY THE BOARD

a. Following Medical Executive Committee approval of Medical Staff General Rules and Regulations, departmental Rules and Regulations, or Medical Staff policies as noted above, such Rules and Regulations or policies shall become effective following approval by the Board. Board approval shall not be withheld unreasonably. Upon approval by the Board, new Rules and Regulations, Policies, or amendments to existing Rules and Regulations or Policies, shall be announced promptly to the Medical Staff in a reasonable manner, as described in Section 13.1-1(b) above.

b. If a proposal is not approved by the Board, then the Medical Executive Committee (or the designated representatives of the group of Medical Staff members who submitted a non-Medical Executive Committee-supported proposal that went directly to the Board) may invoke the conflict management process set forth in Section 13.11 of these Bylaws within 30 days of receiving notice that the proposal was not approved by the Board.

c. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations and policies.

13.1-6 ADHERENCE TO MEDICAL STAFF RULES AND REGULATIONS, MEDICAL STAFF POLICIES, AND HOSPITAL ADMINISTRATIVE POLICIES

Applicants and Members of the Medical Staff and others holding Clinical Privileges or exercising Practice Prerogatives shall be governed by all applicable Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and procedures which have been appropriately approved by the Medical Executive Committee and Board of Directors.

13.2 DUES OR ASSESSMENTS

The Medical Staff shall have the power to adopt the amount of annual dues or assessments, if any, for each category of Medical Staff membership and is solely responsible for the collection, use, and expenditure of Medical Staff funds. Provisional Medical Staff members ~~appointed prior to July 1st of the calendar year will be required to pay dues in full. Medical Staff members appointed after July 1st of calendar year will be required to pay ½ dues~~ shall not be required to pay dues until after serving one year on the medical staff.

13.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. The words used in these Bylaws and the Rules shall be read to apply to both gender and to both the singular and the plural, as the context requires.

13.4 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 the United States Postal Service, first-class postage prepaid. The use of certified or registered mail is optional unless expressly required in these Bylaws. 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, if known or applicable
Name of Department, or committee (c/o Medical Staff Office, or Chief of Staff)
Tahoe Forest Hospital District
Post Office Box 759
Truckee, California 96160

Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital, and, in the absence of proof of earlier receipt, shall be deemed received five days after mailing in accordance with this Section 13.4.

13.5 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS

13.5-1 GENERAL

a. Medical Staff representatives, as designated by the Chief of Staff, shall participate in Hospital deliberations affecting the discharge of Medical Staff responsibilities.

b. The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

13.5-2 EXCLUSIVE CONTRACTING DECISIONS

The Medical Executive Committee shall review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee and individual members of Medical Staff shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

13.6 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges in the Hospital shall maintain in force professional liability insurance from a company authorized to sell insurance (in the State of California for California staff members and in the State of Nevada for Incline Village Staff members) or from an insurance trust incorporated under the laws of one of the United States of America in no less than the minimum amounts, if any, as from time to time may be jointly determined by the Board of Directors and the Medical Executive Committee.

13.7 BYLAWS NOT A CONTRACT

These Bylaws describe the intended relationship between the Medical Staff and its members, as well as between the Medical Staff (including its members) and the Hospital. It is intended that all affected parties and entities shall conduct themselves in good faith conformance with these Bylaws. However, these Bylaws are not intended to be a contract, and technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or for seeking remedies that are contractual in nature.

13.8 Waiver of bylaws/RULES provisions

Insofar as is consistent with applicable laws, the Medical Executive Committee, in consultation with the Board or its designated representative, or the Board, in consultation with the Medical Executive Committee, has the discretion to waive provisions of the Bylaws or Rules, if either determines that this waiver is necessary to serve the best interests of the patients and the Hospital. There is no right to have a request for a waiver considered and/or granted.

13.9 INTERPRETATION / RECONCILIATION OF PROVISIONS

In the event of any ambiguity or in the Medical Staff Bylaws, Rules and Regulations or Policies, or should there be any question of interpretation, the Medical Executive Committee shall have the authority to resolve such matters. In the event of an apparent conflict between the Bylaws and Medical Staff Rules and Regulations, the Bylaws shall prevail. If there is a conflict between

Medical Staff Rules and Regulations and Medical Staff Policies and Procedures, the Rules and Regulations shall prevail.

13.10 MEDICAL STAFF LEGAL COUNSEL

The Medical Staff may, at its expense, retain and be represented by independent legal counsel. The authority to engage legal counsel on behalf of the Medical Staff shall be the prerogative of the Medical Executive Committee; provided, however, that if the Medical Executive Committee declines to exercise this prerogative, a majority of the voting members of the Active Staff may elect to engage legal counsel on behalf of the Medical Staff.

13.11 DISPUTES WITH THE BOARD OF DIRECTORS

In the event of a dispute between the Medical Staff and the Board of Directors relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code section 2282.5, the following procedures shall apply:

13.11-1 INVOKING THE DISPUTE RESOLUTION PROCESS

a. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25% of the members of the Active Staff.

b. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50% of the members of the Active Staff.

13.11-2 DISPUTE RESOLUTION FORUM

a. Ordinarily, the initial forum for dispute resolution should be the Joint Conference Committee.

b. However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Board of Directors. A neutral mediator acceptable to both the Board of Directors and the Medical Executive Committee may be engaged to further assist the dispute resolution upon request of (a) at least a majority of the Medical Executive Committee plus two members of the Board of Directors; or (b) at least a majority of the Board of Directors plus two members of the Medical Executive Committee.

13.11-3 FINAL ACTION

If the parties are unable to resolve the dispute the Board of Directors shall make its final determination, giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Board of Directors' determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital.

13.12 DISPUTES INTERNAL TO THE MEDICAL STAFF

(a) Under the following circumstances, the Medical Executive Committee shall initiate a conflict management process to address a disagreement between members of the Medical Staff and the Medical Executive Committee about an issue relating to the Medical Staff's documents or functions, including but not limited to a proposal to adopt or

amend the Medical Staff Bylaws, Rules and Regulations, or Policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the Medical Staff under these Bylaws (by amending the Bylaws):

(1) upon written petition signed by either:

- at least 25% of the voting members of the Medical Staff, or
- at least 66% of the members of any Department of the Medical Staff; or

(2) upon the Medical Executive Committee's own initiative at any time; or

(3) as otherwise specified in these Bylaws.

(b) A request to invoke the conflict management process must be submitted within any deadline specified in these Bylaws.

(c) A petition to initiate the conflict management process shall designate two Active Medical Staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process should be utilized to address it.

(d) With respect to each particular conflict, the Medical Executive Committee shall determine and specify a process that the Medical Executive Committee deems most appropriate to the issues and circumstances. At a minimum, the conflict management process shall do all of the following:

- provide a reasonably timely, efficient, and meaningful opportunity for the parties to express their views;
- require good-faith participation by representatives of the parties; and
- provide for a written decision or recommendation by the Medical Executive Committee on the issues within a reasonable time, including an explanation of the Medical Executive Committee's rationale for its decision or recommendation.

(e) At the Medical Executive Committee's discretion, the process for management of a conflict between the Medical Executive Committee and Medical Staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts.

(f) This conflict management process shall be a necessary prerequisite to any proposal to the Board of Directors by Medical Staff members for adoption or amendment of a Bylaw, Rules and Regulations provision, or Policy not supported by the Medical Executive Committee, including (but not limited to) a proposed Bylaws amendment intended to remove from the Medical Executive Committee some authority that has been delegated to it by the Medical Staff.

(g) Nothing in this Section is intended to prevent Medical Staff members from communicating with the Board of Directors about Medical Staff Bylaws, Rules and Regulations, or Policies, according to such procedures as the Board may specify.

13.13 HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by an appropriate practitioner, i.e., an MD or DO, DDS, DPM, Clinical Psychologist, oral maxillofacial surgeon, or other qualified licensed individual in accordance with California and/or Nevada law as applicable and the Medical Staff Rules and Regulations.

Whenever the medical history and physical examination have been completed before admission or registration (which may occur only as permitted in accordance with this Section and applicable law and accreditation requirements), an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by an appropriate practitioner, as defined above.

Additional requirements for completing the medical history and physical examination for each patient are set forth in the Medical Staff Rules and Regulations.

ARTICLE XIV

ADOPTION AND AMENDMENT OF BYLAWS

14.1 Medical Staff responsibility and authority

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments, which shall be effective when approved by the Board of Directors. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board of Directors. Amendments to these Bylaws may be submitted for vote by the Medical Executive Committee or by petition signed by at least ten percent (10%) of the voting member of the Medical Staff.

14.2 METHODOLOGY

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

(a) The affirmative vote of two-thirds (2/3) of the Staff members voting on the matter by mailed secret ballot; provided at least 14 days' advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and

(b) Amendments shall become effective when approved by the Board of Directors, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Medical Staff bylaws or rules.

In recognition of the ultimate legal and fiduciary responsibility of the Board of Directors, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Board of Directors to such effect including a reasonable period of time for response, the Board of Directors may impose conditions on the

Medical Staff that are required for continued State licensure, approval by accrediting bodies or to comply with a court judgment. In such event, Medical Staff recommendations and views shall be carefully considered by the Board of Directors in its actions.

The Medical Staff Bylaws, Rules and Regulations and policies will not conflict with the Governing Board Bylaws.

14.3 AMENDMENTS BY PETITION

Generally, proposals to adopt, amend or repeal Bylaws will emanate from or be endorsed by the Medical Executive Committee in accordance with its overall responsibility to represent and act on behalf of the Medical Staff and discharge its various functions as described in Section 10.3 of these Bylaws. However, in addition to the mechanisms set forth above by which the Medical Staff may adopt Medical Executive Committee-proposed amendments to these Bylaws, the Medical Staff may adopt and propose Bylaw amendments directly to the Board of Directors for its approval, but only in accordance with the following procedure:

(a) A proposal to amend the Bylaws may be initiated by submitting to the Medical Staff Office a petition signed by at least 10% of Active Medical Staff members proposing a specific Bylaws amendment or amendments (which will constitute notice of the proposed Bylaws amendment(s) to the Medical Executive Committee). Any such petition must identify two Active Medical Staff members who will serve as representatives and act on behalf of the petition signers in the processes described below (including any conflict management processes).

(b) Upon submission of such a petition, the Medical Executive Committee will determine whether it supports the proposed Bylaws amendment(s), and if so, the Medical Staff Office will arrange for a vote on the proposed Bylaws amendment(s) by the voting members of the Active Medical Staff according to the process described above for voting on Medical Executive Committee-proposed Bylaws amendments.

- If the Medical Staff adopts the proposed Bylaws amendment(s) by a vote of the Medical Staff conducted according to the process described above, then the proposed Bylaws amendment(s) will be submitted to the Board of Directors for approval.
- If the Medical Staff does not adopt the proposed Bylaws amendment(s) by vote, then the proposed Bylaws amendment(s) will be deemed withdrawn.

(c) If the Medical Executive Committee does not support the proposed Bylaws amendment(s), the Medical Executive Committee will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 13.12 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed Bylaws amendment(s) will be deemed withdrawn.

(d) If the conflict is not resolved by withdrawal of the proposed Bylaws amendment(s), or by Medical Executive Committee support of the proposed Bylaws amendment(s) as modified in the conflict management process, then the proposed Bylaws amendment(s) will be submitted (in original form or, if the original proposed Bylaws amendment(s) has/have been modified in the conflict management process, then as modified) to the Medical Staff for a vote. The proposed Bylaws amendment(s) will be submitted to the Board of

Directors if a majority of the Active Medical Staff members who are eligible to vote cast their ballots in favor of the proposed Bylaws amendment(s).

(e) A copy of the Medical Executive Committee's written statement of its decision and reasons issued at the conclusion of the conflict management process shall be provided to the Board of Directors along with any proposed Bylaws amendment(s) submitted to the Board after such process.

(f) Such proposed Bylaws amendment(s) will become effective immediately upon Board approval, which shall not be withheld unreasonably.

(g) If the Board of Directors does not approve the proposed Bylaws amendment(s), then the matter will be referred to the conflict management process set forth in Section 13.11 of these Bylaws.

14.4 EXCLUSIVITY

The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

14.5 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Directors within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and the Board of Directors.

TAHOE FOREST HOSPITAL DISTRICT

MEDICAL STAFF
RULES AND REGULATIONS

2016

MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE I

PREAMBLE

1.1 These Rules are intended to provide for the operation and governance of the Medical Staff in accordance with the guidance and structure set forth in the Medical Staff Bylaws ("Bylaws"). In the event of any conflict between the Bylaws and the Rules, the Medical Staff Bylaws shall prevail.

1.2 All Rules contained herein have been recommended by the Medical Executive Committee of the Tahoe Forest Hospital District Medical Staff and approved by the Board of Trustees in accordance with Section 13.1 of the Medical Staff Bylaws. These Rules are binding on all Members of the Medical Staff and holders of clinical privileges, to the extent consistent with the Bylaws.

1.3 All definitions contained in the Bylaws are incorporated in these Rules.

ARTICLE II
COMMITTEES

2.1 ETHICS COMMITTEE

2.1-1 COMPOSITION

The Ethics Committee shall be composed of at least the following members: One physician, one registered nurse, one clergy, one medical social worker (or comparable), one member of Hospital administration, and one non-Hospital local community member at large. Additional members may be appointed by the Chief of Staff. The chairperson shall be ~~a physician appointed by the Chief of Staff~~ the Member-at-Large, and the vice-chairperson shall be a member selected by the Ethics Committee. The chairman of the Ethics Committee shall serve as a voting member of the Medical Executive Committee.

2.1-2 PURPOSE

The purpose of the Ethics Committee is to impact positively upon the quality of health care provided by the Hospital by:

(a) Providing assistance and resources in decision-making processes that have bioethical implications. The Ethics Committee shall not, however, be a decision maker in any such processes.

(b) Educating members within the Hospital community of bioethical issues and dilemmas.

(c) Facilitating communication about ethical issues and dilemmas among members of the Hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.

(d) Retrospectively reviewing cases to evaluate bioethical implications, and providing policy and educative guidance relating to such matters.

2.1-3 MEETINGS

The Ethics Committee shall meet as often as necessary to accomplish its purpose and shall maintain a limited record of its proceedings and report its activities to the Medical Executive Committee.

2.2 BYLAWS COMMITTEE

2.2-1 COMPOSITION

The Bylaws Committee shall consist of at least three (3) members of the Medical Staff, including at least the Vice Chief of Staff and a past Chief of Staff appointed by the Chief of Staff.

2.2-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) conducting a periodic review of the Medical Staff Bylaws, as well as the Rules and forms promulgated by the Medical Staff and its Departments;

(b) submitting recommendations to the Medical Executive Committee for changes in these documents as necessary and desirable; and

(c) receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of those items.

2.2-3 MEETINGS

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

2.3 QUALITY ASSESSMENT COMMITTEE

2.3-1 COMPOSITION

The Quality Assessment Committee shall consist of a chair of the Committee appointed by the Chief of Staff in consultation with Administration, interested physicians from each clinical Department, and such members as may be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee, including representatives from the Quality Department, Nursing Services, and from Hospital Administration. ~~The chair shall be the Medical Director of Quality Assessment and will also serve as the physician representative to the Critical Access Hospital Committee at Tahoe Forest Hospital.~~

2.3-2 DUTIES

The Quality Assessment Committee shall perform the following duties:

(a) Recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital. These may include mechanisms to:

(1) establish systems to identify potential problems in patient care;

(2) set priorities for action on problem correction;

(3) refer priority problems for assessment and corrective action to appropriate

Department or committees;

(4) monitor the results of quality assessment activities throughout the Hospital; and

(5) coordinate quality assessment activities.

(b) Submit regular reports to the Medical Executive Committee and Board of Directors on the quality of medical care provided, quality review activities conducted, and Professional Review Committee (PRC) and Professional Performance Evaluation Committee (PPEC) functions:
(1) Periodic review of Peer Review Policy
(2) Review of individual cases as requested by department Chairs.

(c) Risk management practices as they relate to aspects of patient care and safety within the Hospital, and ensure that the Medical Staff actively participates, as appropriate, in the following risk management activities related to the clinical aspects of patient care and safety:

(1) The identification of general areas of potential risk in the clinical aspects of patient care.

(2) The development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety and evaluation of these cases.

(3) The correction of problems in the clinical aspects of patient care and safety identified by risk management activities.

(4) The design of programs to reduce risk in the clinical aspects of patient care and safety.

(d) Medical Records: Review and evaluate health information management including paper and electronic health records for compliance with Hospital needs and regulatory requirements. Additional medical record functions include:

(1) ensuring that medical records are maintained at an acceptable standard of completeness
(2) submitting written reports to the Medical Executive Committee and providing recommendations to the Medical Executive Committee regarding corrective action recommendations pertaining to compliance with medical records policies;
(3) recommending new use or changes in the format of medical records;
(4) recommending policies for medical record maintenance including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement; and policies related to privileged communication and release of information;

(e) Blood Usage: The Quality Assessment Committee shall receive quarterly reports to evaluate blood and blood product transfusion appropriateness and usage.

(f) Drug Usage: The Quality Assessment Committee shall be responsible for the oversight of the Pharmacy and Therapeutics Committee and an annual review of the

Medication Error Reporting Policy (MERP)

(g) Infection Control: The Quality Assessment Committee shall be responsible for the oversight of the Infection Control Committee.

(h) Tissue Review: The Quality Assessment Committee shall also be responsible for receiving quarterly reports from a pathologist, who is a member of the Medical Staff with privileges in pathology concerning (I) pre-operative, post-operative, and pathological diagnoses for surgical cases in which no specimen is removed; (II) all transfusions of whole blood and blood derivatives;(III) all removed tissue where the tissue is found to be normal or not consistent with clinical diagnosis. Any cases not meeting criteria established by policy shall be referred to the appropriate Medical Staff Committee or Department for discussion.

(i) The Quality Assessment Committee shall review all deaths and all removed tissue where the tissue is found to be normal or not consistent with the clinical diagnosis, and shall develop and implement measures to correct any problems discovered. It shall develop rules governing which cases must be reviewed, and outlining any exceptions to this general rule. Such rules shall be subject to Medical Executive Committee and Board of Directors approval. The Quality Assessment Committee shall also develop and implement measures to promote autopsies in all cases of unusual death or deaths of medico-legal or educational interest.

(j) The Quality Assessment Committee shall review utilization of resources as they relate to aspects of patient care within Hospital-provided services as outlined in the Utilization Review Plan.

(k) Surgical and other invasive procedures, including: selecting appropriate procedures; preparing the patient for the procedure; equipment availability; safety of the environment; performing the procedure and monitoring the patient; and providing post-procedure care.

(l) Radiation Safety: Report from Radiation Safety Officer regarding research, diagnostic, and therapeutic uses of radioactive materials

(i) Reduction of both personnel and patient exposure to the minimum while pursuing the medical objective.

(ii) All applications for uses or authorizations for uses of radiation will be reviewed by the Radiation Safety Officer to assure that “as low as reasonably achievable” (ALARA) exposures will be maintained.

(iii) When reviewing new uses of radiation, details of efforts of applicants to maintain exposures ALARA must be included.

(m) Imaging Services: The Quality Assessment Committee shall be responsible for establishing, approving and enforcing policies relating to administration of imaging services through the hospital; and

(i) Conducting, approving and interpreting a quality assessment review for radiology services

(n) The Quality Assessment Committee shall be responsible for annual review of the

following:

(i) All clinical/critical pathways.
(ii) Quality Assessment Plan.
(iii) The Utilization Review and Discharge Plan.
(iv) The Risk Management Plan
(iv) The Patient Safety Plan.
(v) The Social Service Plan.

2.3-3 MEETINGS

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

2.4 INTERDISCIPLINARY PRACTICE COMMITTEE

2.4-1 COMPOSITION

The Interdisciplinary Practice Committee ("IDPC") shall include, at a minimum, the Chief Nursing Officer, the Chief Executive Officer or designee, and an equal number of physicians appointed by the Medical Executive Committee of the medical staff, ~~and registered nurses appointed by the Chief Nursing Officer~~. In addition, representatives of the various allied health professions shall ~~ould~~ serve as ~~consultants on an as-needed basis~~ voting members of the IDPC, ~~and, if available, may be included in the committee proceedings when a member of the specialty is applying for privileges~~.

A member of the IDPC may attend meetings of the Medical Executive Committee on an ex-officio basis without a vote.

The chair of the Committee shall be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee.

2.4-2 DUTIES

The Interdisciplinary Practice Committee shall establish written policies and procedure for the conduct of its business including ~~making recommendations regarding the granting of~~ serving as consultants regarding expanded role privileges to ~~registered~~ advanced practice nurses, whether or not employed by the facility and other allied health professionals. These policies and procedures will be administered by the Committee ~~which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges for allied health professionals~~. The Committee shall be responsible for the formulation and adoption of standardized procedures and for initiating the preparation of such standardized procedure in accordance with Title 22.

2.4-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee ~~and Board of Directors~~.

2.5 WELL-BEING COMMITTEE

2.5-1 COMPOSITION

(a) In order to improve the quality of care and promote the competence of the Medical Staff, the Chief of Staff, with the approval of the Medical Executive Committee, shall appoint the Well-Being Committee composed of at least two (2) active members of the Medical Staff. The majority of the committee, including the chair, shall be physicians.

(b) Individuals who are not members of the Medical Staff (including non-physician(s)) may be appointed when such appointment will materially increase the effectiveness of the work of the committee.

(c) The members shall be appointed as appropriate to achieve continuity.

(d) Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.

2.5-2 DUTIES

(a) The Well-Being Committee shall serve as an identified resource to take note of and evaluate issues related to health, well-being, or impairment of Medical Staff members and shall provide assistance to Department Chairs and Medical Staff officers when information and/or concerns are brought forth regarding a Practitioner's health or behavior related to physical, emotional, or drug dependency related conditions.

(b) The committee shall provide advice, recommendations and assistance to any practitioner who is referred and to the referring source, but shall act only in an advisory capacity and not as a substitute for a personal physician.

(c) The Well-Being Committee will receive reports, information and concerns related to the health, well-being, or impairment of Medical Staff members, whether from third parties, upon request of a Medical Staff or department committee or office or upon self-referrals from the practitioners themselves and, as it deems appropriate, may investigate such reports.

(d) With respect to matters involving individual Medical Staff members, the committee may offer advice, counseling, or referrals as may seem appropriate.

(e) Activities shall be confidential; however, if unreasonable risk of harm to patients is perceived, that information must be referred to appropriate officials of the Medical Staff for action as necessary to protect patients and/or for corrective action.

(f) The committee shall assess and determine appropriate outside assistance resources and programs for practitioners also consider general matters related to the health and well being of the Medic al Staff and, with the approval of the Medical Executive Committee, shall develop educational programs or related activities.

(g) The Committee will make a response to the referral source of any written letter of concern regarding well-being but shall not compromise the confidentiality of its activities or the privacy of the individuals concerned.

(h) The Well-Being Committee may be asked to review responses form applicants

concerning physical or mental disabilities, and recommend what, If any, reasonable accommodations may be indicated to assure that the practitioner will provide care in accordance with the Hospital and Medical Staff's standard of care. The timing of these assessments shall be closely coordinated so that the Medical Executive Committee does not consider the issue of physical or mental disabilities until after an applicant has been otherwise determined to be qualified for Medical Staff membership. The Committee shall also perform this function during a Staff membership. The Committee shall also perform this function during member's term, upon request from the Medical Executive Committee.

2.5-3 MEETINGS

The committee shall meet as often as necessary. It shall maintain only such record of its proceedings, as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee. Any records regarding individual practitioners shall be kept strictly confidential and maintained separate from credentials files and other Medical Staff records.

2.6 CANCER COMMITTEE

2.6-1 COMPOSITION

The Cancer Committee is a standing committee of the Medical Staff. It is multidisciplinary and provides leadership to the Cancer Program. The Cancer Committee and Cancer Conference are also known as the Tahoe Forest Hospital's Tumor Board.

The Cancer Committee shall be a multidisciplinary committee composed of physician representatives who care for cancer patients including, but it is not limited to the following:

a. Cancer Committee Chair
b. Cancer Liaison physician
c. Diagnostic Radiologist
d. Medical Oncologist
e. Radiation Oncologist
f. Pathologist
g. Surgeon
h. Gynecologist

Non-physician members must include, but are not necessarily limited to, the following:

a. Cancer program Administrator
b. Oncology nurse
c. Social Workers and/or Case Manager
d. Certified Tumor Registrar
e. Performance Improvement or quality management representative
f. Hospice manager
g. Palliative Care Nurse Specialist
h. Clinical Research Coordinator
i. CoC Appointed Coordinators
j. American Cancer Society Representative
k. Nurse Navigator

The Cancer Committee chair is elected by the physician committee membership for a 2 year term and may also fulfill the role of one of the required physician specialties. Individual members of the Committee are appointed to coordinate important aspects of the Cancer Program. An individual cannot fulfill more than 1 coordinator role (for the CoC appointed

coordinator positions). Each person coordinates one of each of the following four major areas of program activity:

a. Cancer Conference
b. Quality Control of Cancer Registry Data
c. Quality Improvement
d. Community Outreach
e. Clinical Research
f. Psychosocial Services

2.6.2 DUTIES

a. The Cancer Committee develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement and programmatic endeavors related to cancer care;
b. The Cancer Committee establishes the frequency, format and multidisciplinary attendance requirements for cancer conferences on an annual basis;
c. The Cancer Committee ensures that the required number of cases are discussed at the Cancer Conference on an annual basis and that a minimum of 75% of the cases discussed are presented prospectively;
   The Cancer Committee monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective cases presentation annually. Each year, the Cancer Committee participates in the CoC CP3R National Data Outcomes measures. Committee annually reviews outcomes, develops outcomes as indicated and follows the measures through to Quality Improvements projects.
   Each year, the Cancer Committee analyses patient outcomes and disseminates the results of the analysis. This will be accomplished by publishing an Annual Report that includes a cancer site analysis with survival analysis and comparison of our data to NCDB data.

2.6.3 MEETINGS

The Committee shall meet at least quarterly, for a minimum of 4 times each year or as often as necessary at the call of its Chair (currently meets every other month for a total of six meetings per year)). It shall maintain a record of its proceedings and report its activities to the Medical Staff Quality Assessment Committee. Each member is required to attend at least 75% of the Cancer Committee meeting held annually. Participation may include through teleconference. The Cancer Committee needs to monitor the individual attendance of all members and address attendance that does not fulfill the needs of the program or falls below the requirements set forth.

2.7 CANCER CONFERENCE

2.7-1 COMPOSITION:

The Cancer Conference reports to the Cancer Committee. The Cancer Conference shall consist of a multidisciplinary group of physicians including the major disciplines involved in the management of cancer; surgery, medical oncology, radiation oncology, diagnostic imaging and pathology and other specialties as needed. The Chair will be elected by the Cancer Committee.

2.7-2 DUTIES

(a) Utilize the clinical case presentation format to educate the staff in oncology and

oncologic practice;

(b) Promote an active interchange of ideas for case management, assuring that patients with malignancies will benefit from the combined thinking of the staff;

(c) Ensure that a broad base of oncology knowledge is available, either from within the Cancer Conference, or from guest participants;

(d) Accept and consider any responsible and practical method established by a hospital to evaluate cases of malignancy. Whether done by a representative cross section of the staff or specified departments, evaluations shall reflect a broad base of knowledge of oncology, assuring that all patients with malignancies will benefit from the combined thinking of the staff in case management.

(e) Report on new trends in the diagnosis and therapy of malignancy;

(f) Encourage presentations to the Cancer Conference early in the patient's management;

(g) Recommend the most appropriate diagnostic and therapeutic approaches for the patients presented and their malignancies;

(h) Cases presented, at a minimum, include 15% of the annual analytic case load) and the prospective presentation rate (a minimum of 80% or a maximum of 450 of the annual analytic case presentations). Prospective cases include, but are not limited to, the following:

(i) 1. Newly diagnosed and treatment not yet initiated;

(j) 2. Newly diagnosed and treatment initiated, but discussion of additional treatment is needed;

(k) 3. Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed;

(l) 4. Previously diagnosed, and discussion of supportive or palliative care is needed;

(m) 5. Note that cases may be discussed more than once and counted each time as a prospective presentation if management issues are discussed.

Cancer Conference activities are reported to the Cancer Care Committee at least quarterly.

2.7.3 MEETINGS

The Cancer Conference is held monthly or as often as necessary at the call of its chair. Each member is required to attend at least 50% of the Cancer Conferences. The Cancer Committee reviews the annual Cancer Conference attendance rate to ensure compliance with the CoC standard.

2.8 INCLINE VILLAGE COMMITTEE

2.8-1 COMPOSITION

(a) The Incline Village Committee shall consist of all physicians who are on the Medical Staff and exercising clinical privileges at Incline Village Community Hospital.

(b) The Chairperson shall be elected on a bi-annual basis by majority vote of physicians on the committee. The Chairperson shall serve for a three (3)-year term with election held 3 months prior to the last meeting of the calendar year. In addition to the physicians, there will be representation by nursing and Hospital administration.

(c) All medical and hospital staff may attend the Open Session of this meeting, however,

agenda Items must be cleared In advance with the Chairperson.

(d) The Chairperson will serve as liaison between the Administration and the physicians practicing at Incline Village Community Hospital. The Chairperson will report directly to the Medical Executive Committee and attend Medical Executive Committee as a voting member.

2.8-2 DUTIES

a) Review policies and procedures relating to nursing and ancillary services throughout the Incline Village Community Hospital.

b) Conduct all quality review of care at Incline Village Community Hospital with further review or optional alternative review by appropriate Tahoe Forest Hospital District Medical Staff departments if requested. Those specialties that only have one physician representing the specialty will have cases reviewed by the appropriate department of the Tahoe Forest Hospital District Medical Staff . (Department of Surgery will review surgical cases, etc.)

c) Conduct, participate, and make recommendations regarding educational programs pertinent to clinical practice;

d) Reviewing and evaluating Departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

e) Coordinate patient care provided at Incline Village Community Hospital by the Medical Staff with nursing and ancillary patient care services;

f) Submit written reports to the Medical Executive Committee concerning: (1) the Committee's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided at Incline Village Community Hospital and the Hospital; and (3) how quality and utilization review functions will be addressed;

g) Meet regularly for the purpose of considering patient care review findings and the result of the Committee's other review and evaluation activities, as well as reports on other Committee and Medical Staff functions;

h) Take appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

i) Account to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Committee; and

j) Recommend space and other resources needed by the Committee; and assess and recommend off-site sources for needed patient care, treatment and services within the purview of, but not provided directly by the Committee.

2.8-3 MEETINGS

The Incline Village Committee shall meet on a quarterly basis. Additional meetings or cancellations may be determined by the Chairperson. A Committee report will be submitted to the Medical Executive Committee for review. Each member of the Active Staff whose primary

practice is at Incline Village Community Hospital shall be encouraged to attend the Annual Medical Staff meeting; and required to attend at least fifty percent (50%) of all meetings of the Incline Village Committee or the appropriate Tahoe Forest Hospital Department meetings. There will be no exceptions from the meeting attendance requirements.

2.11 MEDICAL EDUCATION COMMITTEE

2.11-1 COMPOSITION

The Medical Education Committee will consist of, at a minimum, the Medical Director of Medical Education who will also act as the chair. The committee will include designated Clerkship Directors and any other participating preceptors. The committee members will be appointed by the Medical Executive Committee. In addition, representatives of the various nursing and allied health professions will participate on an as-needed basis. The Medical Education Committee is accountable to the Medical Executive Committee.

2.11-2 DUTIES

The Medical Education Committee shall establish written policies and procedures for the conduct of its business, including oversight of the medical students, interns, and residents in coordination with the University, College, or School of Medicine. The committee will ensure that the program operates in a structured manner according to the teaching policies of the affiliated University, College or School of Medicine. They will also provide oversight of the medical students, interns, and residents activities and progress in collaboration with the Instructors of Record. The Committee will also provide oversight of telemedicine conferencing, continuing medical education for the Medical Staff, and other programs as assigned. The Committee recommends the acquisition, purchase, or disposal of educational materials and assists in establishing rules and regulations for use of the medical library services by the members of the Medical Staff.

2.11-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair,. Meetings may be held in person or via electronic or e-mail communication. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee.

ARTICLE III

MEETINGS

3.1 AGENDA FOR REGULAR MEDICAL STAFF MEETINGS

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 may include the following:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) verbal or written administrative reports from the Chief of Staff, Departments, and committees, and the Chief Executive Officer;

(c) verbal or written reports by responsible officers, committees, and Departments on the overall

results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;

(d) old business; and

(e) new business.

ARTICLE IV

PATIENT CARE

4.1 ADMISSION AND DISCHARGE OF PATIENTS

4.1-1 The Hospital will accept all patients for care and treatment to the extent it has appropriate facilities and qualified personnel available to provide necessary services or care. Accordingly, the Hospital will not accept patients for care and treatment with severe neurological trauma, severe and extensive third degree burns, and psychiatric patients with suicidal predilection. All physicians shall be governed by the official admitting policy of the Hospital. A patient can be admitted to the Hospital only by practitioners with admitting privileges.

4.1-2 A member of the Medical Staff with clinical privileges appropriate to the patient's needs shall be responsible for the medical care and treatment for each patient in the Hospital, for the prompt completion and accuracy of the medical record, for the necessary special instructions, and for transmitting reports of the condition of the patient to other members of the health care team and to relatives of the patient, subject to legal and privacy limitations. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record stating the date and time of such transfer.

4.1-3 A Conditions of Admission Form signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending Medical Staff member whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the member's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, specific consent that informs the patient of the nature of, and risks inherent in, any special treatment or surgical procedure shall be obtained.

4.1-4 Current medications being used by patients at the time of admission may be used on a continuing basis following admission providing that all such drugs be identified by the Hospital pharmacist and be in authorized identifiable pharmacy containers with appropriate labeling.

4.1-5 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. The admitting practitioner is responsible for informing Hospital administration and the nursing staff at the time of admission if the practitioner suspects the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The attending physician shall initiate any appropriate restrictions with respect to where in the Hospital the patient will be placed (i.e. isolated area for contagious disease) and shall recommend appropriate precautionary measures to protect the patient and others. In the event the patient or others cannot be appropriately protected, arrangements shall be made to transfer the patient to a facility where his or her care can be

appropriately managed.

4.1-6 Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee of the Medical Staff and the administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

4.1-7 A patient admitted on an emergency basis who does not have a private physician may select any physician on the applicable service to attend to him. Where no such selection is made, the member of the Active, Incline Village, or Provisional Staff serving on-call for the appropriate service will be assigned to the patient and contacted by the emergency physician. The chiefs of each service shall provide a schedule for such assignments

4.1-8 Each member of the Medical Staff must assure continuing timely, adequate, professional care for patients under his/her care in the Hospital. Failure of an attending physician to meet these requirements may be a ground for corrective action under the Medical Staff Bylaws. A member of the Medical Staff who will be unavailable must, on the order sheet of the chart of each patient, indicate in writing, the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence. It is the responsibility of the attending practitioner to make prior arrangements with the indicated practitioner, who must have privileges to provide appropriate continuing care.

4.1-9 In the event of a need to categorize admitting priorities in an emergency situation, the Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical Department and approved by the Medical Executive Committee.

4.1-10 As a routine basis for admitting, the admitting policies of the Hospital will be based on the following order of priorities:

(a) Emergency admissions

(b) Urgent admissions

(c) Pre-operative admissions

(d) Routine admissions

4.1-11 Patient transfer priorities shall be as follows:

(a) Emergency Department to appropriate bed.

(b) From obstetrical patient care area to general care area, when medically indicated.

(c) From Intensive Care Unit to general care area. No patient will be transferred from the ICU without such transfer being approved by the responsible physician.

4.1-12 For the protection of patients, the medical and nursing staffs and the Hospital, due to the lack of adequate facilities and personnel for the treatment of patients with serious mental illness and patients who may be dangerous to themselves and/or others, such patients shall be transferred to an appropriate facility when medically stable. When the transfer of such patients is not possible, the patient may be temporarily admitted to the general area of the Hospital with appropriate nursing and security supervision to allow for crisis intervention as

available through community and Medical Staff clinical psychological/psychiatric services.

4.1-13 Any patient known or suspected to be suicidal or otherwise a danger to self, who is treated as a Hospital inpatient or through the Emergency Department should be offered a psychological or psychiatric consultation through available community and Medical Staff resources.

4.1-14 If any question as to the necessity of admission to, or discharge from the Intensive Care Unit should arise, appropriate review of the decision is to be made by the Medical Director of the Intensive Care Unit in consultation with the attending physician.

4.1-15 The attending physician is required to document the need for continued hospitalization after specific periods of stay per disease categories as defined by the Medical Staff. This medical record documentation must contain:

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

(b) The estimated period of time the patient will need to remain in the Hospital.

(c) Plans for post-Hospital care.

4.1-16 The patient shall be discharged from the Hospital only on a written order of the attending Medical Staff member. If the patient indicates an intent to leave the hospital before the completion of treatment or contrary to the advice of the patient's attending practitioner, the nursing staff shall contact the patient's attending practitioner to arrange for the patient to discuss his or her plan with the attending practitioner before the patient leaves. The attending practitioner shall advise the patient of the implications of leaving the hospital against medical advice, including the risks involved and the benefits of remaining for treatment, and shall document this in the medical record. Should a patient insist upon leaving, the Hospital against the advice of the attending Medical Staff member or without proper discharge, a notation of the incident shall be made on the patient's medical record, and the patient shall be asked to sign the appropriate "Leaving Hospital Against Medical Advice" form acknowledging that they are leaving against medical advice and their understanding of the medical risks and possible consequences of refusing continued treatment at the hospital. If the patient cannot be located or refuses to sign the form, the nursing staff who witnessed the refusal shall sign the form and document in the patient's medical record the facts surrounding the patient's departure.

4.1-17 In the event of a hospital death, the deceased patient shall be pronounced dead by the attending physician or his/her designated covering physician within a reasonable period of time, or by a registered nurse who has been certified to pronounce a patient's death pursuant to the nursing standardized procedure. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease where the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of deceased patients shall conform to local law.

The patient's attending physician is responsible for notifying the next of kin in all cases of patient death and shall facilitate the reporting of patient deaths to the coroner or to other agencies as required by laws.

(a) If the basis for pronouncement of death is "brain death" (i.e. the total and irreversible cessation of all functions of the entire brain, including the brain stem), death must be pronounced by a physician, and a second, independent physician must confirm the

determination of brain death. Both physicians must document their findings in the patient's record. The patient's family must be informed of the patient's death. If the family objects to terminating treatment or contests the accuracy of the diagnosis, hospital administration shall be advised and consulted before medical interventions (e.g. respiratory) are discontinued.

(b) If the patient or the patient's family indicates that the patient has or will contribute anatomical gifts, the hospital protocol for identifying potential organ and tissue donors shall be followed.

4.1-8 Except in the case of patients hospitalized less than 48 hours and in cases of normal obstetrical deliveries and normal newborn infants, in which case a final progress note may be substituted, a clinical resume discharge summary shall be written or dictated on all medical records of hospitalized patients.

4.2 AUTOPSIES

4.2-1 It shall be the duty of all Medical Staff members to secure meaningful autopsies whenever appropriate, as described below, and consistent with applicable law. An autopsy may be performed only with a written authorization signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist, or by a physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete autopsy protocol should be made a part of the deceased's medical record within 60 days. Autopsies are felt to be of particular value in the following circumstances and the Medical Staff is encouraged to actively seek family permission for autopsy for all in-patient deaths meeting these criteria:

(a) Deaths where there are significant questions related to the effectiveness of therapy.

(b) Deaths where there are significant questions relating to the extent of disease.

(c) Deaths where ante mortem diagnostic procedures have resulted in unusual or unexplained findings.

(d) Deaths where genetic diseases are suspected but not confirmed prior to death. An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy costs.

An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy rates.

4.3 MEDICAL RECORDS

4.3-1 The attending Medical Staff member shall be responsible for the complete and legible medical record for each patient. Its contents shall be pertinent and current. The medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services, its contents shall be pertinent and current. The inpatient record shall have appropriate identification data;

including, but not limited to:

(a) Chief complaint resulting in admission

(b) History of present illness

(c) Personal and family history

(d) Applicable systems review

(e) Physical examination

(f) Special reports such as consultation, clinical laboratory and radiology services

(g) Provisional diagnosis

(h) Medical or surgical treatment

(i) Operative reports, when appropriate

(j) Pathological finding, when appropriate

(k) Progress notes

(l) Final diagnosis

(m) Condition on discharge

(n) Summarizing clinical resume

(o) Autopsy report when performed

(p) Procedural, therapeutic, and operative consents when appropriate

(q) Post-discharge follow-up plans and medications

4.3-2 All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated by signature. Clinical entries may be counter signed by physicians caring for the same patient.

4.3-3 The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission, but an interval admission note must be written at the time of admission that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.4 HISTORY AND PHYSICAL

4.4.1 A complete admission history and physical examination shall be completed no more than 30 days before or 24 hours after admission, and it must be recorded in the patient's medical record within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history and physical examination has been recorded and a physical examination performed within 30 days prior to

the patient's admission to the Hospital, a legible copy of these reports the report may be used in lieu of the admission history and report of the physical examination report, provided that an appropriate assessment is performed, including a physical examination within the previous 24 hours to update any components of the patient's medical status that may have changed since the earlier history and physical or to address any areas where more current data is needed. In such instances, a physician or other practitioner qualified to perform the history and physical writes an interval admission note addressing the patient's current status and/or any changes to such status, which includes all additions to the history and any subsequent changes in the physical findings. This update examination must be completed and documented in the patient's medical record by an appropriately qualified and privileged member of the Medical Staff within 24 hours after admission. If the history and physical that was performed prior to the patient's admission is determined to be incomplete, inaccurate or otherwise unacceptable, the physician responsible for the update examination may disregard the existing history and physical, and perform a new history and physical. Any such history and physical must be completed and documented in a timely manner, as described these Rules these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded at the time of admission. All such outside records of histories and physicals shall be on a form approved by the Hospital and compatible with the current medical record system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the Hospital's medical record.

4.4-2 When a patient is readmitted to the Hospital within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available in a unit record.

4.4-3 When a patient is admitted for a hospitalization under 48 hours, a Short Stay History and Physical form may be used in lieu of a regular history and physical format. On patients admitted from the emergency room for a short stay, the emergency room record will be deemed sufficient, provided that it is complete and contains at least the same information as indicated necessary on the Short Stay History and Physical form.

4.4-4 The medical record system utilized by the Hospital shall be a unit record system.

4.4-5 When a history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending physician states in writing that such delay would be detrimental to the patient. However, this requirement shall not preclude rendering emergency medical or surgical care to a patient in dire circumstances, as documented by the attending physician.

4.4-6 The attending physician shall authenticate by countersignature the history, physical examination and preoperative note when they have been recorded by an authorized allied health professional, a medical student, or resident staff physician from an outside educational institution performing preceptorship at the Hospital.

4.4-7 The history and physical examination may be performed and documented by any physician permitted by law as long as a physician who is currently a member of the Medical Staff, with privileges to perform a history and physical examination, updates the history and physical examination consistent with these Rules and Regulations. This shall include at least the following:

a. Review of the history and physical examination document;

b. Determination that the information is compliant with the hospital's defined content

requirements for history and physical examinations;

c. Obtaining missing information through further assessment as needed;

d. Update information and findings as necessary:

1. Inclusion of absent or incomplete required information;
2. A description of the patient's condition and course of care since the history and physical examination was performed;
3. A signature, date and time on any document with updated or revised information as an attestation that it is current.

The history and physical examination must have been performed within thirty days prior to the patient's admission to the hospital and the update must be completed and documented in the patient's medical record within 24 hours of admission and on the day of any outpatient surgical procedure.

4.5 PROGRESS NOTES

4.5-1 Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written daily on all acute care patients. In addition, appropriate progress notes shall be written at least every week on swing bed patients.

4.6 OPERATIVE NOTE

4.6-1 Complete operative reports shall be dictated or written immediately after surgery, specifying the surgeon, procedure, diagnosis, anesthesia, and pertinent findings. The complete operative report shall include, but not be limited to:

(a) Surgeons, assistant surgeons, and anesthesiologist

(b) Type of anesthesia

(c) Detailed procedural account

(d) Any remarkable or unusual findings

(e) Complications

(f) Tissue removal and disposition

(g) Drains, appliances, or prostheses used

(h) Post-op condition

(i) Disposition from the operating room

4.7 CONSULTATIONS

4.7-1 Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of the consultation. When operative procedures are involved, the consultation note shall, except in an emergency situation so verified on the record, be recorded prior to the operation. Consultations must be signed by the consultant.

4.7-2 Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.

4.7-3 The good conduct of medical practice includes the proper and timely use of consultations. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rest with the practitioner responsible for the care of the patient. Except in cases of emergency, when time does not permit, consultation should be obtained in the following situations:

(a) when the patient is not a good risk for operation or treatment;

(b) when the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(c) where there is doubt as to the choice of therapeutic measures to be utilized;

(d) in unusually complicated situations where specific skills of other practitioners may be

needed;

(e) in instances in which the patient exhibits severe psychiatric symptoms; and

(f) when requested by the patient or his/her family.

4.7-4 Appropriate pediatric consultation in the wards should be considered for sick children under the following circumstances:

(a) A prolonged hospitalization if a child is involved with potential medical pediatric problems (e.g., multiple trauma, septic orthopedic problems, acute burns).

(b) Infectious problems of a life threatening nature (e.g., epiglotitis, meningitis).

(c) Other problems involving intensive care hospitalization (e.g., diabetes, ketoacidosis, and status asthmaticus).

(d) All patients admitted for surgical procedures less than two years of age.

4.7-5 The attending Medical Staff member should request consultations when the patient would seemingly benefit by the additional skills or abilities of other practitioners. The attending Medical Staff member is responsible for directly requesting the consultant to assist and he/she shall provide written authorization to permit another practitioner to attend or examine the patient, except in an emergency. The attending physician shall document the order for the consultant in the Physician Orders section and also indicate of the reason for the consultation on the Physician Orders section or Progress Notes in the patient's medical record. A consultation has not been fully requested or authorized unless the attending Medical Staff member has personally contacted the consultant or the consultant's office and the attending member has written a note in the chart. No practitioner is obligated to accept any request for consultation.

4.7-6 If a nurse or licensed registered pharmacist has any reason to doubt or question the care provided to any patient or believes appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the nursing supervisor who in turn may refer the matter to the Nursing Executive. The Nursing Executive may bring the matter to the attention of the chief of the Department where the practitioner has privileges. Where circumstances are such to justify such action, the chief of the Department may himself/herself request the consultation.

4.8 ABBREVIATIONS

4.8-1 Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of unapproved abbreviations shall be kept on file in the Medical Record Department.

4.8-2 Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and timed, dated and signed by the responsible Medical Staff member at the time of discharge of all patients.

4.9 CONSENTS

4.9-1 Unless otherwise authorized by law, written authorization of the patient, guardian or other legally authorized individual is required for release of medical information to persons not

otherwise authorized to receive this information.

4.10 REMOVAL AND ACCESS OF MEDICAL RECORDS: CONFIDENTIALITY

4.10-1 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken away without the written approval of the Chief Executive Officer. Unauthorized removal of charts from the Hospital is grounds for corrective action, to be determined by the Medical Executive Committee of the Medical Staff.

4.10-2 In case of re-admission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or another.

4.10-3 Access to medical records may be afforded to members of the Medical Staff for a bona fide study and research consistent with preserving the confidentiality of professional individually-identifiable information concerning the individual patients. All such projects and access shall be approved by a duly constituted Institutional Review Committee in accordance with applicable state and federal law, including the HIPAA Privacy Regulations. Approval must also be obtained from the Medical Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, and in accordance with applicable laws, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering the periods during which they attended such patients in the Hospital.

4.10-4 A medical record shall not be permanently filed until it is completed by the responsible Medical Staff member or is ordered filed by the Medical Executive Committee in the event that the Medical Staff member is permanently unable to sign.

4.11 ORDERS

4.11-1 A Medical Staff member's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the Medical Staff member. All pre-printed orders shall be reviewed annually by the Medical Executive Committee for appropriateness.

4.12 MEDICAL RECORD DELINQUENCY

4.12-1 The patient's medical records shall be completed at the time of discharge, or in no event later than 14 days following discharge. This will include progress notes, final diagnosis, and a dictated clinical resume. If the record still remains incomplete 15 days after discharge, the Medical Records Manager shall notify the Medical Staff member by certified, receipted mail that his/her privileges to admit or attend patients shall be suspended 7 days from the date of notice, and such Medical Staff members shall remain suspended until the records have been completed. The admitting office shall be notified of this action. Ongoing care of patients already in the Hospital may be continued. The suspended member shall not care for any patients other than those currently admitted under his/her own name and may not provide consults on Hospital or emergency room patients. If the suspended member is on call, he/she is responsible for finding another physician to see any patients requiring care while he/she is on call. Suspension of admitting privileges does not affect the Medical Staff member's privilege to provide patient care in emergency circumstances when the suspended member is the only provider available to provide that necessary care. Any member whose privileges have been suspended for failure to complete medical records in a timely fashion for a total of thirty (30) days or longer in a twelve (12) month period may be reported to the Medical Board

of California by the Chief Executive Officer, pursuant to California Business and Professions Code section 805 and the National Practitioner Data Bank.

4.13 LONG TERM CARE

4.13-1 Physicians must visit their Long Term Care residents as needed and at least every 30 days unless there is an alternate schedule. Any change of condition must be documented in the progress notes. Progress notes and orders must be signed and dated at the time of the visit. Histories and physicals must be updated yearly. Histories and Physicals for residents, and updated Histories and Physicals for residents returning to ECC from Acute must be completed within 48 hours of admission to ECC. Failure to comply with the above constitutes a deficiency. Physicians will be notified by the Extended Care Center Director of Nursing, in writing, of any Extended Care Center record deficiencies. address the matter as warranted. A suspension may be imposed pending correction of the deficiency.

4.14 VERBAL AND WRITTEN ORDERS

4.14-1 All orders for treatment shall be in writing. Verbal orders are to be used infrequently. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom the orders were dictated, with the name of the ordering practitioner per his/her own name noted. The date and time the orders were received shall also be noted. The responsible prescriber or another practitioner who is responsible for the care of the patient and is authorized to write orders shall authenticate such orders by signature, date and time, within 48 hours. Duly authorized persons who may receive verbal orders or telephone orders for orders within their scope of practice are licensed registered nurses, licensed vocational nurses, occupational therapists, speech therapists, pharmacists, laboratory technologists, respiratory therapists, physical therapists, and medical nutritional therapists.

4.14-2 A practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

4.14-3 All previous orders are cancelled when patients are transferred to surgery.

4.14-4 A qualified full-time, part time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. The radiologist or other practitioner who performs radiology services including nuclear medicine must sign reports of his or her own interpretations.

4.14-5 Radiology Services must be provided only on the order of practitioners with clinical privileges or, consistent with State Law, other practitioners authorized by the medical staff and the governing body to order the services.

4.15 GENERAL RULES REGARDING SURGICAL CARE

4.15-1 All surgical patients must receive a pre-operative study so that an accurate diagnostic impression as well as an estimated operative risk to the patient can be clearly established prior to proceeding with the surgical treatment.

4.15-2 Surgeons must be in the operating room and ready to commence operations at the time scheduled. As the anesthesiologist will not administer anesthesia until the surgeon is present or is in the immediate area, the surgeon should arrive at least 10 minutes before the scheduled surgery. Repeated tardiness problems shall be handled by the Chair of Surgery

and/or the OR supervisor and may result in the temporary restriction of scheduling privileges.

4.15-3 Surgery scheduling:

(a) Surgery shall be scheduled on the following priority situations:

(1) Emergency:

(a) Acute life threatening situation.

(b) Acute sensory or limb threatening situation - surgery must begin with all deliberate speed.

(2) Urgency: Sub acute situation where undue delay will produce irreversible damage. Surgery will begin at the earliest available time appropriate for the degree of urgency.

(3) Elective: Chronic, relapsing, or volitional situations where postponement would create no undue risk or hardship. Surgery is scheduled at a time mutually convenient for the patient, surgeon, and Hospital.

(b) Priority scheduling should appropriately reflect the patient's situation and not reflect the surgeon's situation. Abuse of priority scheduling may result in restriction or suspension of OR privileges.

4.15-4 The medical record must document a thorough physical examination prior to the performance of surgery. When the history and physical examination is not recorded prior to the time stated for the operation, the patient will not be taken into the surgical suite.

4.15-5 Except in severe emergencies, the pre-operative diagnosis and laboratory tests must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, there must be adequate documentation. In any emergency, the physician shall make at least a comprehensive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.

4.15-6 All anatomical parts, foreign objects and tissues removed at the operation shall be sent to the Hospital pathologist for examination excluding teeth. The pathologist's authenticated report shall be made a part of the patient's medical record.

4.15-7 All tissues of potential diagnostic value removed in the Emergency Department shall be sent to the Hospital pathologist for examination. Other tissues, such as fragments from debridement of wounds, foreign bodies, etc., removed in the Emergency Department shall be submitted to the Hospital pathologist at the discretion of the physician performing the removal excluding teeth.

4.15-8 Written and signed surgical consents shall be obtained prior to the operative procedure except in situations wherein the patient's life is in jeopardy, when suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a temporarily or permanently incompetent adult or minor for whom consent for surgery cannot be immediately obtained, the circumstances should be fully explained in the patient's medical record.

4.15-9 The surgeon should exercise professional judgment in selecting an assistant who is capable of

safely concluding the procedure if necessary.

4.15-10 Oral and maxillofacial surgeons may admit and perform history and physical examinations without supervision as long as they provide documentation of training and experience and are granted the clinical privilege to do so. Otherwise, a patient admitted for dental or podiatric care is a dual responsibility involving the dentist and/or podiatrist and a physician member of the Medical Staff.

(a) Dentist and podiatrist responsibilities:

(1) A detailed dental and/or podiatric history justifying the Hospital admission.

(2) A detailed description of the examination of the oral cavity/lower extremity and a pre-operative diagnosis.

(3) A complete operative report, describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissues with the exception of teeth and fragments shall be sent to the Hospital pathologist for examination.

(4) Progress notes pertinent to the oral/podiatric condition.

(5) Clinical resume statement at the time of discharge.

(b) Physician's responsibilities:

(1) A medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general medical status while hospitalized.

(c) The discharge of patients shall be on written order of the dentist and/or podiatrist member of the Medical Staff with the written concurrence of the attending physician involved.

4.15-11 Operations shall be scheduled through the surgical services office, or with the appropriate nursing shift supervisor. A surgical log shall be maintained for the scheduling of all surgeries. The surgical assistant, if required, shall be stated at the time surgery is scheduled.

4.15-12 For all outpatient surgical cases, local post-operative coverage will be provided by the attending Medical Staff member or by an alternate Medical Staff member by pre-arrangement.

4.15-13 A complete admission history and physician examination shall be recorded within 24-hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports may be used In lieu of the admission history and report of the physician examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded within 24 hours prior to commencing the surgery. All such outside records shall be on a form approved by the Hospital and compatible with the current medical records system. The admitting practitioner

may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the hospital's medical records.

4.16 GENERAL RULES REGARDING ANESTHESIA CARE

4.16-1 A pre anesthesia evaluation (is documented) by an individual qualified to administer anesthesia performed within 48 hours prior to surgery. Anesthesia is defined as general, regional, or MAC. The pre anesthesia evaluation documentation must include the following:

4.16-1.1 A patient interview to assess medical history, anesthetic history and medication history, and allergy history, including anesthesia risk.

4.16-1.2 An appropriate physician exam that includes, at a minimum airway assessment, a pulmonary exam to include auscultation of the lungs, and a cardiovascular exam.

4.16-1.3 Review of objective diagnostic data.

4.16.1-4 Assignment of ASA physical status.

4.16.1-5 The anesthesia plan and discussion of risks and benefits of the plan with the patient or the patient's legal representative.

4.16.1-6 Assessment of pain management using visual scale of zero to ten or the "FACES" tool for children.

4.16-2 There is an intra-operative Anesthesia Record. This record accurately reflects critical techniques, management, and patient responses including condition at the end of the anesthetic. The intra operative anesthesia record must include the following time-based record of events.

4.16-2.1 Immediate review prior to initiation of anesthetic procedures including patient re-evaluation and a check of equipment, drugs and gas supply.

4.16-2.2 Monitoring of the patient.

4.16-2.3 Amounts of drugs and agents used, and times of administration.

4.16-2.4 The types and amounts of intravenous fluids used, including blood and blood products, and times of administration.

4.16-2.5 The techniques used.

4.16-2.6 Unusual events during the administration of anesthesia.

4.16-2.7 The status of the patient at the conclusion of anesthesia.

4.**16-3** With respect to inpatients, a postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery. For the outpatient surgical patient, this post anesthesia assessment must be done prior to discharge from the facility. At a minimum, the post anesthesia assessment follow up report documents the following:

4.16-3.1 Cardiopulmonary status.

4.16-3.2 Level of consciousness.

4.16-3.3 Any follow up care and/or observations, and patient instructions.

4.16-3-4 Any complications occurring during post-anesthesia recovery.

4.17 GENERAL RULES REGARDING HOME CARE

4.17-1 Patients requiring home care services shall have a written order from the attending physician. Such orders shall be reviewed at least every sixty (60) days.

4.17-2 Treatment plans shall be signed by the physician no later than thirty (30) days after initiation of service.

4.18 GENERAL RULES REGARDING EMERGENCY CARE

4.18-1 All patients who present to the Emergency Department of either Tahoe Forest Hospital or IVCH shall be given a medical screening examination by an Emergency Department physician. Patients determined to have an emergency medical condition shall be given such

stabilizing treatment as necessary within the capabilities of the facility, including consultation and treatment by specialty physicians if applicable. Any discharge or transfer of emergency patients shall be done in accordance with the Hospital's policy regarding the treatment and transfer of emergency patients. Such policy shall be in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Classifications of staff who may conduct medical screening examinations in accordance with EMTALA shall include: (a) in the Emergency Department, licensed physicians in accordance with their privileges; and (b) in the Women and Family Center, licensed physicians in accordance with their privileges and registered nurses who have been approved to perform such examinations based on demonstrated competence and action pursuant to approved standardized procedures.

4.18-2 Medical Staff members shall provide call coverage according to schedules drawn up by the IVCH Medical Director for IVCH and by the Chiefs of the Anesthesia, Medicine, Ob/Pediatrics and Surgical Departments for Tahoe Forest Hospital District.

4.18-3 A physician on call, upon being called for an acute emergency patient, must respond within 30 minutes.

4.18-4 Should a difference of opinion exist between the referring emergency physician and the on-call doctor as to patient management and disposition, the emergency physician, being physically present and responsible for the patient's care, shall direct the immediate patient management. Decisions shall primarily reflect what is best for the patient. When resolutions of the differing opinions are not immediately achieved and the on-call specialist continues to disagree on the need for his/her treatment, the emergency doctor may:

(a) Contact the relevant Department chairperson for assistance in resolving the matter or,

(b) Call another appropriate physician from the on-call roster.

Issues raised by the conflicting opinions shall be discussed at the next Departmental meeting with additional referral to the Medical Executive Committee as needed.

4.18-5 Any on-call Medical Staff member who fails to respond in a timely manner or who refuses to consult on and attend an emergency patient at the request of the Emergency Department physician shall be subject to corrective action by the Medical Executive Committee, in accordance with the Medical Staff Bylaws.

4.18-6 Out of town practitioners who are not members of the Medical Staff shall not use the Emergency Department to care for any patients, friends or relatives. All practitioners wishing to utilize the Emergency Department must submit applications and satisfy all other requirements for staff privileges as stated in the Medical Staff Bylaws and these Rules.

4.18-7 An appropriate medical record shall be kept for every patient receiving emergency service and this record shall be incorporated into the patient's records, if such exists. The records shall include:

(a) Adequate patient information.

(b) Information concerning the time of the patient's arrival.

(c) Pertinent history of the injury or illness including details relative to first aid or

emergency care given to the patient prior to his arrival at the Hospital.

(d) Description of significant clinical, laboratory, and radiographic findings.

(e) Diagnosis.

(f) Treatment given.

(g) Condition of the patient on discharge or transfer.

(h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

(I) Method of arrival.

4.18-8 Each patient’s medical record shall be signed by the physician in attendance who is responsible for its clinical accuracy.

4.19 **Rehabilitative Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology)**

4.19-1 Rehabilitative Services must be provided by individuals who are licensed as specified in the California Business & Professions Code for the functions to be performed. A licensed physical therapist, occupational therapist or speech therapist may be authorized by the Medical Staff, through the process described in the Allied Health Professional Manual, to hold and exercise such privileges as are consistent with the scope of his or her license and the hospital licensing laws. These privileges shall include, but not necessarily be limited to, the authority to receive and implement orders as described below.

4.19-2 Rehabilitative Services must be furnished in accordance with a written plan of treatment, and in accordance with the orders of duly authorized practitioners. The orders must be incorporated in the patient's medical record.

4.19-3 The initial order for Rehabilitative Services must be issued in writing by a physician, who shall retain overall responsibility for the patient's care. The order should state the reasons for the referral, and may specify: "Evaluate patient, develop a plan of care, and implement plan." It may also be more limited in scope or more detailed, at the discretion of the physician. It may not state, simply: "Evaluate and treat." Pre-printed orders may be approved by the Medical Executive Committee to enhance the efficiency of the ordering process.

4.19-4 If the physician's order provides for the therapist to develop and implement a plan of care, the therapist shall document the plan in the medical record, and shall collaborate with the physician before the plan is implemented or modified. The documented plan shall include the type, amount, frequency and duration of the service to be provided, and indicate the diagnosis and anticipated goals. The physician's approval of the plan or modification, which may be conveyed orally while collaborating with the therapist, shall be documented by the therapist in the medical record.

REGULAR MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Thursday, May 25, 2017 at 4:00 p.m.
Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. **CALL TO ORDER**

Meeting was called to order at 4:00 p.m.

2. **ROLL CALL**

Board: Charles Zipkin, M.D., Board President; Dale Chamblin, Treasurer; Alyce Wong, R.N., Board Member

Staff: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Alex MacLennan, Chief Human Resources Officer; Matt Mushet, In-House Counsel; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel; Rick Rybicki, Rybicki & Associates

Absent: Randy Hill, Secretary (Director Greg Jellinek resigned effective May 9, 2017)

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

No changes were made to the agenda.

4. **INPUT AUDIENCE**

No public comment was received.

Open Session recessed at 4:02 p.m.

5. **CLOSED SESSION**

5.1. Conference with Labor Negotiator (Government Code § 54957.6)

Name of District Negotiator(s) to Attend Closed Session: Alex MacLennan and Richard Rybicki
Employee Organization(s): Employees Association and Employees Association of Professionals

Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155)

Subject Matter: First Quarter 2017 Corporate Compliance Report – Closed Session
Number of items: One (1)

Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)

Subject Matter: First Quarter 2017 Service Excellence Quality Report – Closed Session
Number of items: One (1)

◈ Denotes Action Item

Discussion was held on a privileged item.

5.4. Approval of Closed Session Minutes◈
04/27/2017
Discussion was held on a privileged item.

5.5. TIMED ITEM – 5:30PM – Hearing (Health & Safety Code § 32155)◈
Subject Matter: Medical Staff Credentials
Discussion was held on a privileged item.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER
Open Session reconvened at 6:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel reported of the five items on the closed session agenda, Items 5.1-5.3 had no reportable actions. Item 5.4 Approval of Closed Session Minutes and Item 5.5 Medical Staff Credentials were approved on a 3-0 vote.

9. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

10. INPUT – AUDIENCE
No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS
No public comment was received.

12. ACKNOWLEDGMENTS
12.1. Martha Waters was named May 2017 Employee of the Month.

13. CITIZENS OVERSIGHT COMMITTEE
13.1. Citizens Oversight Committee Measure C Final Report
Gerald Herrick presented the Citizens Oversight Committee Measure C Final Report.

13.2. Citizens Oversight Committee Acknowledgement
Board President presented Gerald Herrick and Citizens Oversight Committee with a board proclamation.

No public comment was received.

14. MEDICAL STAFF EXECUTIVE COMMITTEE
14.1. Medical Executive Committee (MEC) Meeting Consent Agenda◈
MEC recommends the following for approval by the Board of Directors: Annual review and approval of policies and procedures, Annual Clinical Policy and Procedure Approvals for

◈ Denotes Action Item

Occupational Health, MultiSpecialty Clinics and Cancer Center, Amendment to Community Medicine Privilege Form, Annual Clinical Policy and Procedure Approvals for Obstetrics and Pediatrics include W&F Center P&P's, and Annual IVCH Policy and Procedure Approvals for Dietary & MNT, Diagnostic Imaging, Case Management, Environmental Services, Infection Control, Nursing Services, Surgical Services, and Laboratory

Discussion was held.

ACTION: Motion made by Director Wong, seconded by Director Chamblin, to approve the Medical Executive Committee Meeting Consent Agenda as presented.
AYES: Directors Wong, Chamblin and Zipkin
NAYS: None
Abstention: None

15. CONSENT CALENDAR ◈

These items are expected to be routine and non-controversial. They will be acted upon by the Board without discussion. Any Board Member, staff member or interested party may request an item to be removed from the Consent Calendar for discussion prior to voting on the Consent Calendar.

15.1. Approval of Minutes of Meetings
04/27/2017

15.2. Contracts
- **15.2.1.** Catherine Colpitts, D.O. – Physician Recruitment Agreement for Conditional Loan Repayment
- **15.2.2.** Matthew Mingrone, M.D. – Professional Services Agreement
- **15.2.3.** Paul Haeder, M.D. – Professional Services Agreement
- **15.2.4.** Paul Haeder, M.D. – Physician Recruitment Agreement for Conditional Loan Repayment
- **15.2.5.** Brooks Rohlen, M.D. – Medical Directorship Agreement for Pallative Medicine Program

15.3. Staff Reports (Information Only)
- **15.3.1.** CEO Board Report
- **15.3.2.** COO Board Report
- **15.3.3.** CNO Board Report
- **15.3.4.** CIO Board Report
- **15.3.5.** CMO Board Report

15.4. Policies
- **15.4.1.** Order & Decorum

Director Zipkin pulled item 15.4.1. Order and Decorum.

ACTION: Motion made by Director Chamblin, seconded by Director Wong, to accept the Consent Calendar as presented without Item 15.4.1. Order and Decorum.
AYES: Directors Wong, Chamblin and Zipkin
NAYS: None
Abstention: None

16. ITEMS FOR BOARD ACTION ◈

16.1. TFHD Board of Directors Vacancy

◈ Denotes Action Item

DRAFT

General Counsel advised the Board of Directors could consider appointing the vacant board seat or calling a special election.

Discussion was held.

No public comment was received.

ACTION: **Motion made by Director Wong, seconded by Director Chamblin, to appoint the vacant seat on the Board of Directors.**
AYES: Directors Wong, Chamblin and Zipkin
NAYS: None
Abstention: None

17. ITEMS FOR BOARD DISCUSSION

17.1. Compliance Program

17.1.1. First Quarter 2017 Compliance Program Report

Jim Hook of The Fox Group presented the first quarter Compliance Program Report to the Board of Directors.

No public comment was received.

17.2. Financial Report

CFO presented the April 2017 Financial Report.

Discussion was held.

No public comment was received.

17.3. New TFHD Staff

17.3.1. In-House Counsel

CEO introduced TFHD's new In-House Counsel, Matt Mushet, to the Board of Directors and highlighted the efficiencies and savings of the position to the District.

Discussion was held.

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Discussion was held on item 15.4.1.

Staff was directed to change "majority vote" to "unanimous vote" on number 16.

ACTION: **Motion made by Director Chamblin, seconded by Director Wong, to approve Item 15.4.1. Order and Decorum with the change noted above.**
AYES: Directors Wong, Chamblin and Zipkin
NAYS: None
Abstention: None

DRAFT

19. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

19.1. Board Quality Committee Meeting – 05/09/2017
Director Wong provided an update from the recent Quality Committee meeting.

19.2. Board Personnel Committee Meeting – 05/16/2017
Director Wong provided an update from the recent Personnel Committee meeting.

19.3. Board Finance Committee Meeting – No meeting held in May.

19.4. Community Benefit Committee Meeting – No meeting held in May.

19.5. Governance Committee Meeting – No meeting held in May.

20. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS
None.

21. ITEMS FOR NEXT MEETING
None.

22. BOARD MEMBERS REPORTS/CLOSING REMARKS
None.

23. CLOSED SESSION CONTINUED, IF NECESSARY
Not applicable.

24. OPEN SESSION
Not applicable.

25. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
Not applicable.

26. ADJOURN
Meeting adjourned at 6:39 p.m.

DRAFT

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is June 22, 2017 at 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

DRAFT

TAHOE FOREST HOSPITAL DISTRICT
MAY 2017 FINANCIAL REPORT
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Board of Directors
Of Tahoe Forest Hospital District

MAY 2017 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the eleven months ended May 31, 2017.

Activity Statistics

- TFH acute patient days were 388 for the current month compared to budget of 343. This equates to an average daily census of 12.52 compared to budget of 11.10.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Surgical cases, Laboratory tests, Mammography exams, Ultrasounds, Cat Scans, PET CT, Pharmacy units, Oncology Pharmacy units, Respiratory Therapy, Physical Therapy, Speech Therapy, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Home Health visits, Oncology Lab, and Nuclear Medicine exams.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 55.0% in the current month compared to budget of 54.0% and to last month's 59.1%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 55.5%, compared to budget of 54.1% and prior year's 57.9%.
- EBIDA was $1,056,303 (5.0%) for the current month compared to budget of $125,378 (.7%), or $930,925 (4.3%) above budget. Year-to-date EBIDA was $16,451,590 (7.2%) compared to budget of $7,485,382 (3.5%), or $8,966,208 (3.7%) above budget.
- Cash Collections for the current month were $11,578,501 which is 94% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 52.6, compared to the prior month of 55.4. Gross Accounts Receivables are $31,985,922 compared to the prior month of $33,799,541. The percent of Gross Accounts Receivable over 120 days old is 17.9%, compared to the prior month of 19.1%.

Balance Sheet

- Working Capital Days Cash on Hand is 50.3 days. S&P Days Cash on Hand is 205.7. Working Capital cash increased $2,909,000. Accounts Payable decreased $1,112,000, Accrued Payroll & Related Costs increased $501,000, cash collections fell short of target by 6%, and the District received its second installment of property tax revenues.
- Net Patients Accounts Receivable decreased approximately $1,269,000. Cash collections were at 94% of target and days in accounts receivable were 52.6 days, a 2.8 days decrease.
- Other Receivables and GO Bond Receivables decreased $1,990,000 and $1,480,000, respectively, after booking the second installment of property tax revenues.
- GO Bond Tax Revenue Fund increased $1,872,000 due to the receipt of property tax revenues.
- Accounts Payable decreased $1,112,000 due to the timing of the final check run in May.
- Accrued Payroll & Related Costs increased a net $501,000 due to an increase in accrued payroll days at the close of May.
- Estimated Settlements, Medi-Cal and Medicare decreased a net $446,000 after truing up the IGT receivable reserve booked at the close of FY2016.

Operating Revenue

- Current month's Total Gross Revenue was $21,026,067, compared to budget of $18,113,809 or $2,912,257 above budget.
- Current month's Gross Inpatient Revenue was $5,534,924, compared to budget of $5,320,886 or $214,038 above budget.
- Current month's Gross Outpatient Revenue was $15,491,143 compared to budget of $12,792,924 or $2,698,219 above budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 33.3% Medicare, 19.0% Medi-Cal, .0% County, 5.5% Other, and 42.2% Insurance compared to budget of 34.8% Medicare, 17.6% Medi-Cal, .0% County, 3.6% Other, and 44.0% Insurance. Last month's mix was 31.4% Medicare, 18.1% Medi-Cal, .0% County, 5.3% Other, and 45.2% Insurance.
- Current month's Deductions from Revenue were $9,464,498 compared to budget of $8,333,434 or $1,131,064 over budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 1.55% decrease in Medicare, a 1.28% increase to Medi-Cal, a .0% decrease in County, a 1.91% increase in Other, and Commercial was under budget 1.64%, 2) Revenues exceeded budget by 16.1% and 3) a true-up of the FY16 IGT reserves was completed, resulting in a positive variance in Prior Period Settlements.

Operating Expenses

DESCRIPTION	May 2017 Actual	May 2017 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	4,172,340	3,771,707	(400,633)	Negative variance in Salaries and Wages related to increased patient volumes.
Employee Benefits	1,488,223	1,377,186	(111,037)	Annual employee BBQ, longevity retention bonuses, and employer related payroll taxes created a negative variance in Employee Benefits.
Benefits – Workers Compensation	52,083	57,011	4,928	
Benefits – Medical Insurance	432,790	694,217	261,427	
Professional Fees	1,957,150	1,695,415	(261,735)	We saw negative variances in Hospitalist and Emergency Department physician fees, Chief Medical Officer physician fees, service line analysis consulting, PT, ST, and OT therapist fees, locums coverage for Radiation Oncology, and legal services provided to Human Resources
Supplies	1,658,252	1,576,609	(81,643)	Small equipment purchases, patient care staff uniforms, system conversion supplies, and an increase in Patient & Other Medical Supplies due to revenues exceeding budget by 23.93% created a negative variance in Supplies.
Purchased Services	1,041,091	877,166	(163,925)	Services provided to laundry & linen, engineering, expense advances to TIRHR and the Foundation's BOTC & GUGC events, and collection agency fees created a negative variance in Purchased Services.
Other Expenses	613,143	651,054	37,911	Positive variance in Other Expenses related to a decrease in budgeted travel expenses for the Mercy EPIC conversion, Multi-Specialty Clinic rents, and expense advances budgeted for TIRHR and the BOTC & GUGC.
Total Expenses	11,415,073	10,700,366	(714,707)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
May 2017

	May-17	Apr-17	May-16	
ASSETS				
CURRENT ASSETS				
* CASH	$ 18,181,969	$ 15,272,639	$ 16,956,307	1
PATIENT ACCOUNTS RECEIVABLE - NET	17,647,971	18,916,639	12,103,488	2
OTHER RECEIVABLES	3,378,764	5,368,431	2,832,972	3
GO BOND RECEIVABLES	(996,187)	483,445	(982,765)	4
ASSETS LIMITED OR RESTRICTED	5,838,143	5,949,042	5,220,539	
INVENTORIES	2,729,601	2,727,579	2,365,579	
PREPAID EXPENSES & DEPOSITS	1,636,274	1,905,086	1,326,172	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	721,221	642,240	3,147,972	
TOTAL CURRENT ASSETS	49,137,756	51,265,101	42,970,264	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	56,244,140	56,244,140	50,888,997	1
BANC OF AMERICA MUNICIPAL LEASE	246,537	246,537	979,155	
TOTAL BOND TRUSTEE 2002	3	3	2	
TOTAL BOND TRUSTEE 2015	1,572,285	1,436,554	1,113,902	
GO BOND PROJECT FUND	231,734	231,866	3,259,544	
GO BOND TAX REVENUE FUND	3,975,142	2,103,577	3,397,316	5
DIAGNOSTIC IMAGING FUND	3,179	3,179	2,979	
DONOR RESTRICTED FUND	1,146,114	1,146,114	1,139,848	
WORKERS COMPENSATION FUND	6,076	28,841	14,487	
TOTAL	63,425,210	61,440,811	60,796,229	
LESS CURRENT PORTION	(5,838,143)	(5,949,042)	(5,220,539)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	57,587,067	55,491,769	55,575,690	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(140,146)	(140,146)	202,785	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	129,821,675	130,172,530	126,151,868	
GO BOND CIP, PROPERTY & EQUIPMENT NET	33,192,847	32,968,366	31,098,590	
TOTAL ASSETS	270,435,552	270,593,972	256,835,551	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	507,483	510,715	546,271	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,469,762	1,469,762	2,071,949	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	6,291,248	6,314,953	1,932,307	
GO BOND DEFERRED FINANCING COSTS	493,237	495,171	299,623	
DEFERRED FINANCING COSTS	200,774	201,814	213,257	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 8,962,503	$ 8,992,415	$ 5,063,407	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 4,593,207	$ 5,704,974	$ 5,471,732	6
ACCRUED PAYROLL & RELATED COSTS	9,221,460	8,720,231	8,168,653	7
INTEREST PAYABLE	891,881	799,919	492,611	
INTEREST PAYABLE GO BOND	1,290,818	975,326	1,431,935	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	205,097	651,548	278,649	8
HEALTH INSURANCE PLAN	1,307,731	1,307,731	1,307,731	
WORKERS COMPENSATION PLAN	1,120,980	1,120,980	404,807	
COMPREHENSIVE LIABILITY INSURANCE PLAN	751,298	751,298	824,203	
CURRENT MATURITIES OF GO BOND DEBT	1,260,000	1,260,000	530,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	1,953,186	1,953,186	2,323,994	
TOTAL CURRENT LIABILITIES	22,595,656	23,245,193	21,234,315	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	27,715,330	27,821,197	29,597,138	
GO BOND DEBT NET OF CURRENT MATURITIES	103,355,606	103,369,026	99,997,435	
DERIVATIVE INSTRUMENT LIABILITY	1,469,762	1,469,762	2,071,949	
TOTAL LIABILITIES	155,136,354	155,905,178	152,900,837	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	123,115,588	122,535,095	107,858,273	
RESTRICTED	1,146,114	1,146,114	1,139,848	
TOTAL NET POSITION	$ 124,261,701	$ 123,681,208	$ 108,998,121	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
MAY 2017

1. Working Capital is at 50.3 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 205.7 days. Working Capital cash increased a net $2,909,000. Accounts Payable decreased $1,112,000 (See Note 4), Accrued Payroll & Related Costs increased $501,000 (See Note 5), cash collections fell short of budget by 6%, and the District received its second funding of property tax revenues in the amount of $2,542,000.

2. Net Patient Accounts Receivable decreased approximately $1,269,000. Cash collections were 94% of target. Days in Accounts Receivable are at 52.6 days compared to prior months 55.4 days, a 2.8 days decrease.

3. Other Receivables decreased a net $1,990,000 after booking the receipt of the second installment of property tax revenues.

4. GO Bond Receivables decreased a net $1,480,000 after booking the receipt of the second installment of property tax revenues.

5. GO Bond Tax Revenue Fund increased $1,872,000 due to the receipt of the second installment of property tax revenues.

6. Accounts Payable decreased $1,112,000 due to the timing of the final check run in the month.

7. Accrued Payroll & Related Costs increased $501,000 as a result of increased accrued payroll days in May.

8. Estimated Settlements, Medi-Cal and Medicare decreased a net $446,000 after truing up the IGT receivable reserve booked at the close of FY2016.

Tahoe Forest Hospital District
Cash Investment
May 2017

WORKING CAPITAL			
US Bank	$ 16,887,855		
US Bank/Kings Beach Thrift Store	48,209		
US Bank/Truckee Thrift Store	129,255		
US Bank/Payroll Clearing	115,926		
Umpqua Bank	1,000,723		
Total			$ 18,181,969
BOARD DESIGNATED FUNDS			
US Bank Savings	$ -	0.03%	
Capital Equipment Fund	-		
Total			$ -
Building Fund	$ -		
Cash Reserve Fund	56,244,140	0.93%	
Local Agency Investment Fund			$ 56,244,140
Banc of America Muni Lease			$ 246,537
Bonds Cash 2002			
Bonds Cash 2002			$ 3
Bonds Cash 2015			$ 1,572,285
Bonds Cash 2008			$ 4,206,876
DX Imaging Education	$ 3,179	0.00%	
Workers Comp Fund - B of A	6,076		
Insurance			
Health Insurance LAIF	-	0.00%	
Comprehensive Liability Insurance LAIF	-	0.00%	
Total			$ 9,255
TOTAL FUNDS			$ 80,461,065
RESTRICTED FUNDS			
Gift Fund			
US Bank Money Market	$ 8,363	0.03%	
Foundation Restricted Donations	$ 98,331		
Local Agency Investment Fund	1,039,420	0.00%	
TOTAL RESTRICTED FUNDS			$ 1,146,114
TOTAL ALL FUNDS			$ 162,068,243

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
MAY 2017

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD MAY 2016
				OPERATING REVENUE						
$ 21,026,067	$ 18,113,809	$ 2,912,257	16.1%	Total Gross Revenue	$ 229,873,849	$ 216,175,553	$ 13,698,296	6.3%	1	$ 200,647,836
				Gross Revenues - Inpatient						
$ 1,935,308	$ 1,772,269	$ 163,039	9.2%	Daily Hospital Service	$ 21,503,671	$ 19,792,337	$ 1,711,334	8.6%		$ 18,737,819
3,599,616	3,548,617	50,999	1.4%	Ancillary Service - Inpatient	44,156,671	42,344,441	1,812,230	4.3%		39,356,842
5,534,924	5,320,886	214,038	4.0%	Total Gross Revenue - Inpatient	65,660,342	62,136,778	3,523,564	5.7%	1	58,094,661
15,491,143	12,792,924	2,698,219	21.1%	Gross Revenue - Outpatient	164,213,507	154,038,776	10,174,732	6.6%		142,553,175
15,491,143	12,792,924	2,698,219	21.1%	Total Gross Revenue - Outpatient	164,213,507	154,038,776	10,174,732	6.6%	1	142,553,175
				Deductions from Revenue:						
9,471,169	7,428,860	(2,042,309)	-27.5%	Contractual Allowances	97,824,625	88,503,079	(9,321,546)	-10.5%	2	80,401,923
619,043	634,203	15,160	2.4%	Charity Care	6,927,155	7,570,055	642,901	8.5%	2	6,307,159
3,850	-	(3,850)	0.0%	Charity Care - Catastrophic Events	282,956	-	(282,956)	0.0%	2	619,863
14,616	270,370	255,754	94.6%	Bad Debt	(1,745,539)	3,234,584	4,980,123	154.0%	2	(531,031)
(644,181)	-	644,181	0.0%	Prior Period Settlements	(1,088,542)	-	1,088,542	0.0%	2	(2,385,299)
9,464,498	8,333,434	(1,131,064)	-13.6%	Total Deductions from Revenue	102,200,655	99,307,718	(2,892,936)	-2.9%		84,412,615
45,337	64,919	(19,582)	-30.2%	Property Tax Revenue- Wellness Neighborhood	686,801	723,122	658,203	91.0%		668,760
864,469	980,449	(115,979)	-11.8%	Other Operating Revenue	8,200,875	7,783,359	417,515	5.4%	3	7,568,260
12,471,375	10,825,743	1,645,632	15.2%	TOTAL OPERATING REVENUE	136,560,870	125,374,316	11,186,554	8.9%		124,472,241
				OPERATING EXPENSES						
4,172,340	3,771,707	(400,633)	-10.6%	Salaries and Wages	42,857,717	42,108,028	(749,689)	-1.8%	4	40,036,200
1,488,223	1,377,186	(111,037)	-8.1%	Benefits	14,049,761	13,416,357	(633,404)	-4.7%	4	13,642,406
52,083	57,011	4,928	8.6%	Benefits Workers Compensation	599,972	627,123	27,151	4.3%	4	564,108
432,790	694,217	261,427	37.7%	Benefits Medical Insurance	6,944,187	7,636,386	692,198	9.1%	4	7,098,955
1,957,150	1,695,415	(261,735)	-15.4%	Professional Fees	20,088,149	19,464,344	(623,805)	-3.2%	5	17,304,746
1,658,252	1,576,609	(81,643)	-5.2%	Supplies	17,868,877	18,390,416	521,539	2.8%	6	16,548,878
1,041,091	877,166	(163,925)	-18.7%	Purchased Services	11,215,733	9,798,657	(1,417,076)	-14.5%	7	9,865,249
613,143	651,054	37,911	5.8%	Other	6,484,883	6,447,623	(37,260)	-0.6%	8	5,464,889
11,415,073	10,700,366	(714,707)	-6.7%	TOTAL OPERATING EXPENSE	120,109,281	117,888,934	(2,220,346)	-1.9%		110,525,432
1,056,303	**125,378**	**930,925**	**742.5%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**16,451,590**	**7,485,382**	**8,966,208**	**119.8%**		**13,946,808**
				NON-OPERATING REVENUE/(EXPENSE)						
461,163	441,581	19,582	4.4%	District and County Taxes	4,913,067	4,848,378	64,689	1.3%	9	4,332,867
391,933	391,933	-	0.0%	District and County Taxes - GO Bond	4,311,267	4,311,267	-	0.0%		4,321,997
62,437	42,243	20,194	47.8%	Interest Income	554,463	394,328	160,135	40.6%	10	337,694
2	-	2	0.0%	Interest Income-GO Bond	359	(0)	360	0.0%		17,640
18,830	38,917	(20,086)	-51.6%	Donations	388,648	428,084	(39,436)	-9.2%	11	393,186
-	-	-	0.0%	Gain/ (Loss) on Joint Investment	(183,517)	(93,750)	(89,767)	-95.8%	12	(121,610)
-	-	-	0.0%	Loss on Impairment of Asset		-	-	0.0%	12	-
-	-	-	0.0%	Gain/ (Loss) on Sale of Equipment		-	-	0.0%	13	7,500
-	-	-	0.0%	Impairment Loss		-	-	0.0%	14	-
(967,356)	(966,316)	(1,040)	-0.1%	Depreciation	(10,167,984)	(10,629,477)	461,493	4.3%	15	(9,386,995)
(101,021)	(98,269)	(2,752)	-2.8%	Interest Expense	(1,124,003)	(1,087,864)	(36,140)	-3.3%	16	(1,303,396)
(327,710)	(315,492)	(12,219)	-3.9%	Interest Expense-GO Bond	(2,407,465)	(2,511,735)	104,270	4.2%		(2,943,836)
(461,722)	(465,404)	3,681	0.8%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(3,715,167)	(4,340,769)	625,603	14.4%		(4,344,952)
$ 594,580	**$ (340,026)**	**$ 934,606**	**274.9%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 12,736,423**	**$ 3,144,612**	**$ 9,591,811**	**305.0%**		**$ 9,601,856**
				NET POSITION - BEGINNING OF YEAR	**111,525,278**					
				NET POSITION - AS OF MAY 31, 2017	**$ 124,261,701**					
5.0%	**0.7%**	**4.3%**		**RETURN ON GROSS REVENUE EBIDA**	**7.2%**	**3.5%**	**3.7%**			**7.0%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
MAY 2017

Variance from Budget — Fav / <Unfav>

1) Gross Revenues

Acute Patient Days were above budget 13.12% or 43 days. Swing Bed days were under budget 44.83% or 13 days. Inpatient Ancillary revenues exceeded budget by 1.40% due to the increase in Acute patient days.

Outpatient volumes were above budget in the following departments: Emergency Department visits, Surgical cases, Laboratory tests, Diagnostic Imaging, Mammography, MRI exams, Ultrasounds, Cat Scans, PET CT, Physical Therapy, Speech Therapy, Occupatonal Therapy, Pharmacy units, and Oncology Pharmacy units.

	MAY 2017	YTD 2017
Gross Revenue -- Inpatient	$ 214,039	$ 3,523,908
Gross Revenue -- Outpatient	2,698,219	10,174,388
Gross Revenue -- Total	$ 2,912,257	$ 13,698,296

2) Total Deductions from Revenue

The payor mix for May shows a 1.55% decrease to Medicare, a 1.28% increase to Medi-Cal, 1.91% increase to Other, County at budget, and a 1.64% decrease to Commercial when compared to budget. Contractual Allowances were over budget due to revenues exceeding budget by 16.10% and a shift in Payor Mix from Medicare and Commerical to Medi-Cal and Other.

A true-up of FY2016 IGT reserves created a positive variance in Prior Period Settlements.

	MAY 2017	YTD 2017
Contractual Allowances	$ (2,042,309)	$ (9,321,546)
Charity Care	15,160	642,901
Charity Care - Catastrophic	(3,850)	(282,956)
Bad Debt	255,754	4,980,123
Prior Period Settlements	644,181	1,088,542
Total	$ (1,131,064)	$ (2,892,936)

3) Other Operating Revenue

Retail Pharmacy revenues fell short of budget by 17.59%.

Hospice Thrift Stores revenues fell short of budget by 16.74%.

Funds received from the Medi-Cal PRIME program came in below budget, creating a negative variance in Miscellaneous.

	MAY 2017	YTD 2017
Retail Pharmacy	$ (41,487)	$ (186,764)
Hospice Thrift Stores	(15,131)	(93,329)
The Center (non-therapy)	(3,692)	(3,442)
IVCH ER Physician Guarantee	(4,569)	48,098
Children's Center	10,780	29,867
Miscellaneous	(65,880)	619,086
Oncology Drug Replacement	-	-
Grants	4,000	4,000
Total	$ (115,979)	$ 417,515

4) Salaries and Wages

	MAY 2017	YTD 2017
Total	$ (400,633)	$ (749,689)

Salaries and Wages exceeded budget due to the increase in patient volumes and use of Registry services. Negative variance was offset, in part, by a positive variane in PL/SL and Standby.

Employee Benefits

Negative variance in Nonproductive related to the annual employee BBQ and Longevity Retention Bonuses.

Employer related payroll taxes created a negative variance in Other.

	MAY 2017	YTD 2017
PL/SL	$ 27,367	$ (261,728)
Nonproductive	(89,875)	(262,373)
Pension/Deferred Comp	(803)	(3,501)
Standby	26,178	191,910
Other	(73,903)	(297,713)
Total	$ (111,037)	$ (633,404)

Employee Benefits - Workers Compensation

	MAY 2017	YTD 2017
Total	$ 4,928	$ 27,151

Employee Benefits - Medical Insurance

	MAY 2017	YTD 2017
Total	$ 261,427	$ 692,198

5) Professional Fees

Negative variance in TFH Locums related to Hospitalist and Emergency Department coverage.

Physical, Speech, and Occupational Therapy volumes exceeded budget by 24.4%, creating a negative variance in The Center (includes OP Therapy).

Chief Medical Officer fees and services provided for service line analyses created a negative variance in Administration.

Negative variance in Oncology related to Locums coverage for Radiation Oncology.

Legal services provided to Human Resources created a negative variance in this category.

Tahoe City Physical and Occupational Therapy volumes exceeded budget, creating a negative variance in TFH/IVCH Therapy Services.

	MAY 2017	YTD 2017
TFH Locums	$ (81,730)	$ (563,564)
The Center (includes OP Therapy)	(170,923)	(328,222)
Miscellaneous	(2,820)	(320,796)
Administration	(41,262)	(309,612)
Information Technology	(6,900)	(190,341)
Multi-Specialty Clinics Admin	4,500	(57,409)
Oncology	(17,776)	(50,045)
Human Resources	(16,452)	(30,152)
IVCH ER Physicians	(2,525)	(10,619)
Home Health/Hospice	50	(1,254)
Medical Staff Services	(333)	(1,244)
Respiratory Therapy	-	(2)
Patient Accounting/Admitting	-	-
Business Performance	-	-
Sleep Clinic	4,292	17,598
Marketing	2,375	26,125
Managed Care	2,162	29,539
Financial Administration	2,120	51,197
TFH/IVCH Therapy Services	(28,773)	64,036
Corporate Compliance	35,217	333,899
Multi-Specialty Clinics	57,043	717,061
Total	$ (261,735)	$ (623,805)

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
MAY 2017

Variance from Budget — Fav / <Unfav>

6) Supplies

Small Equipment purchases for MSC ENT, Sterile Processing, Dietary, Laboratory, Engineering, and Information Technology created a negative variance in Minor Equipment.

Scrubs purchased for the Patient care staff, Sterile Processing concentrate, Engineering supplies, and system conversion supplies created a negative variance in Other Non-Medical Supplies.

Surgical Services and Medical Supplies Sold To Patients revenues exceeded budget by 23.93%, creating a negative variance in Patient & Other Medical Supplies.

Pharmaceutical purchases for the Multi-Specialty Clinics came in below budget, creating a positive variance in Pharmacy Supplies.

	MAY 2017	YTD 2017
Minor Equipment	$ (11,041)	$ (77,803)
Other Non-Medical Supplies	(54,274)	(57,143)
Food	6,741	(7,068)
Imaging Film	624	4,906
Office Supplies	8,262	66,302
Patient & Other Medical Supplies	(63,003)	120,157
Pharmacy Supplies	31,049	472,187
Total	$ (81,643)	$ 521,539

7) Purchased Services

Services provided to Laundry & Linen, Engineering, and expenses advanced to TIRHR and the BOTC & GUGC fundraising events created a negative variance in Miscellaneous.

Facility wide maintenance and repairs created a negative variance in Department Repairs.

Negative variance in Patient Accounting related to collection agency fees.

Negative variance in Hospice related to a billing pass thru for patients residing at Eastern Plumas Healthcare.

Pre-employment screenings and purchased services budgeted for Human Resources fell short of budget estimations, creating a positive variance in this category.

	MAY 2017	YTD 2017
Miscellaneous	$ (104,897)	$ (1,050,859)
Department Repairs	(37,193)	(141,639)
Patient Accounting	(17,628)	(117,464)
Hospice	(50,262)	(114,634)
Pharmacy IP	1,543	(62,439)
Laboratory	(4,945)	(39,527)
Diagnostic Imaging Services - All	(8,952)	(24,640)
Multi-Specialty Clinics	1,756	(3,753)
The Center	240	(2,999)
Information Technology	(1,785)	8,101
Community Development	2,700	17,194
Medical Records	3,014	23,905
Human Resources	52,484	91,677
Total	$ (163,925)	$ (1,417,076)

8) Other Expenses

Unbudgeted rental expense on the Pioneer Commerce Center building created a negative variance in Other Building Rent.

Outside Travel budgeted for the Mercy EPIC conversion came in below budget, creating a positive variance in Outside Training & Travel.

Electricity, Water & Sewer, and Communication costs exceeded budget, creating a negative variance in Utilities.

Expenses advanced to TIRHR and the Foundation for the BOTC and GUGC events came in below budget, creating a positive variance in Miscellaneous.

	MAY 2017	YTD 2017
Human Resources Recruitment	$ (8,347)	$ (194,393)
Other Building Rent	(48,729)	(164,253)
Outside Training & Travel	51,969	(48,475)
Equipment Rent	(4,849)	(37,187)
Utilities	(15,095)	(21,664)
Physician Services	9	(470)
Insurance	(1,378)	230
Multi-Specialty Clinics Equip Rent	739	6,869
Dues and Subscriptions	(2,933)	64,581
Marketing	3,325	70,686
Multi-Specialty Clinics Bldg Rent	11,809	73,639
Miscellaneous	51,390	213,178
Total	$ 37,911	$ (37,260)

		MAY 2017	YTD 2017
9) District and County Taxes	Total	$ 19,582	$ 64,689
10) Interest Income	Total	$ 20,194	$ 160,135
11) Donations	IVCH	$ -	$ 24,267
	Operational	(20,086)	(63,703)
	Capital Campaign	-	-
	Total	$ (20,086)	$ (39,436)
12) Gain/(Loss) on Joint Investment	Total	$ -	$ (183,517)
13) Gain/(Loss) on Sale	Total	$ -	$ -
15) Depreciation Expense	Total	$ (1,040)	$ 461,493
16) Interest Expense	Total	$ (2,752)	$ (36,140)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
MAY 2017

CURRENT MONTH					YEAR TO DATE					PRIOR YTD
ACTUAL	BUDGET	VAR$	VAR%		ACTUAL	BUDGET	VAR$	VAR%	Note	MAY 2016
				OPERATING REVENUE						
$ 1,379,051	$ 1,364,514	$ 14,536	1.1%	Total Gross Revenue	$ 16,941,655	$ 16,614,227	$ 327,428	2.0%	1	$ 15,857,847
				Gross Revenues - Inpatient						
$ -	$ 2,914	$ (2,914)	-100.0%	Daily Hospital Service	$ 32,328	$ 29,141	$ 3,188	10.9%		$ 45,711
-	3,323	(3,323)	-100.0%	Ancillary Service - Inpatient	44,416	37,178	7,238	19.5%		60,044
-	6,237	(6,237)	-100.0%	Total Gross Revenue - Inpatient	76,744	66,319	10,425	15.7%	1	105,755
1,379,051	1,358,278	20,773	1.5%	Gross Revenue - Outpatient	16,864,911	16,547,908	317,003	1.9%		15,752,092
1,379,051	1,358,278	20,773	1.5%	Total Gross Revenue - Outpatient	16,864,911	16,547,908	317,003	1.9%	1	15,752,092
				Deductions from Revenue:						
523,824	446,304	(77,520)	-17.4%	Contractual Allowances	6,040,350	5,395,783	(644,567)	-11.9%	2	5,129,385
45,228	51,327	6,099	11.9%	Charity Care	572,386	625,321	52,936	8.5%	2	527,923
4,057	-	(4,057)	0.0%	Charity Care - Catastrophic Events	45,195	-	(45,195)	0.0%	2	70,529
63,808	49,280	(14,528)	-29.5%	Bad Debt	569,018	600,375	31,357	5.2%	2	572,461
-	-		0.0%	Prior Period Settlements	(22,833)	-	22,833	0.0%	2	(199,758)
636,916	546,911	(90,005)	-16.5%	Total Deductions from Revenue	7,204,115	6,621,479	(582,637)	-8.8%	2	6,100,540
68,156	73,280	(5,123)	-7.0%	Other Operating Revenue	855,167	809,826	45,341	5.6%	3	906,320
810,291	890,883	(80,592)	-9.0%	TOTAL OPERATING REVENUE	10,592,707	10,802,575	(209,868)	-1.9%		10,663,627
				OPERATING EXPENSES						
262,617	264,417	1,800	0.7%	Salaries and Wages	2,900,009	3,058,708	158,699	5.2%	4	2,783,515
118,008	120,940	2,932	2.4%	Benefits	1,089,944	1,074,312	(15,633)	-1.5%	4	931,501
1,965	1,417	(548)	-38.7%	Benefits Workers Compensation	22,026	15,584	(6,442)	-41.3%	4	23,678
26,203	44,618	18,415	41.3%	Benefits Medical Insurance	443,427	490,803	47,376	9.7%	4	454,883
236,446	241,921	5,475	2.3%	Professional Fees	2,623,006	2,611,195	(11,811)	-0.5%	5	2,518,056
65,562	76,230	10,669	14.0%	Supplies	709,703	902,402	192,699	21.4%	6	797,684
42,807	41,942	(866)	-2.1%	Purchased Services	516,273	483,231	(33,042)	-6.8%	7	455,860
57,454	52,981	(4,474)	-8.4%	Other	592,315	597,117	4,802	0.8%	8	632,505
811,063	844,467	33,404	4.0%	TOTAL OPERATING EXPENSE	8,896,704	9,233,352	336,648	3.6%		8,597,682
(772)	**46,416**	**(47,188)**	**-101.7%**	**NET OPERATING REV(EXP) EBIDA**	**1,696,003**	**1,569,223**	**126,781**	**8.1%**		**2,065,945**
				NON-OPERATING REVENUE/(EXPENSE)						
-	-	-	0.0%	Donations-IVCH	24,267	-	24,267	0.0%	9	35,656
-	-	-	0.0%	Gain/ (Loss) on Sale		-	-	0.0%	10	-
(64,277)	(64,277)	(0)	0.0%	Depreciation	(652,434)	(707,042)	54,609	-7.7%	11	(616,021)
(64,277)	(64,277)	(0)	0.0%	TOTAL NON-OPERATING REVENUE/(EXP)	(628,166)	(707,042)	78,876	11.2%		(580,365)
$ (65,049)	**$ (17,860)**	**$ (47,188)**	**-264.2%**	**EXCESS REVENUE(EXPENSE)**	**$ 1,067,837**	**$ 862,181**	**$ 205,657**	**23.9%**		**$ 1,485,580**
-0.1%	**3.4%**	**-3.5%**		**RETURN ON GROSS REVENUE EBIDA**	**10.0%**	**9.4%**	**0.6%**			**13.0%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
MAY 2017

Variance from Budget — Fav<Unfav>

1) Gross Revenues

Acute Patient Days were under budget by 1 at 0 and Observation Days fell short of budget by 1 at 1.

Outpatient volumes exceeded budget in Emergency Department visits, Laboratory tests, Diagnostic Imaging, Cat Scans, and Pharmacy units.

	MAY 2017	YTD 2017
Gross Revenue -- Inpatient	$ (6,237)	$ 10,425
Gross Revenue -- Outpatient	20,773	317,003
	$ 14,536	$ 327,428

2) Total Deductions from Revenue

We saw a shift in our payor mix with a 6.52% decrease in Commercial Insurance, a 9.31% increase in Medicare, a 1.76% decrease in Medicaid, a 1.04% decrease in Other, and County was at budget. We saw a negative variance in Contractual Allowances due to the shift in Payor Mix from Commercial to Medicare.

	MAY 2017	YTD 2017
Contractual Allowances	$ (77,520)	$ (644,567)
Charity Care	6,099	52,936
Charity Care-Catastrophic Event	(4,057)	(45,195)
Bad Debt	(14,528)	31,357
Prior Period Settlement	-	22,833
Total	$ (90,005)	$ (582,637)

3) Other Operating Revenue

	MAY 2017	YTD 2017
IVCH ER Physician Guarantee	$ (4,569)	$ 48,098
Miscellaneous	(554)	(2,757)
Total	$ (5,123)	$ 45,341

4) Salaries and Wages

	MAY 2017	YTD 2017
Total	$ 1,800	$ 158,699

Employee Benefits

	MAY 2017	YTD 2017
PL/SL	$ 10,590	$ 12,687
Standby	3,323	12,815
Other	(2,287)	(4,169)
Nonproductive	(8,890)	(40,228)
Pension/Deferred Comp	196	3,261
Total	$ 2,932	$ (15,633)

Employee Benefits - Workers Compensation

	MAY 2017	YTD 2017
Total	$ (548)	$ (6,442)

Employee Benefits - Medical Insurance

	MAY 2017	YTD 2017
Total	$ 18,415	$ 47,376

5) Professional Fees

Health Clinic physician fees came in below budget, creating a positive variance in Miscellaneous.

Sleep Clinic physician fees are tied to collections which fell short of budget in May.

Negative variance in Therapy Services related to reclassification of therapy professional fees based on submitted invoices from Agility.

	MAY 2017	YTD 2017
Miscellaneous	$ 12,208	$ (21,388)
Administration	1,393	(18,089)
IVCH ER Physicians	(2,525)	(10,619)
Foundation	(692)	(3,914)
Multi-Specialty Clinics	(962)	(34)
Sleep Clinic	4,292	17,598
Therapy Services	(8,238)	24,636
Total	$ 5,475	$ (11,811)

6) Supplies

Food costs exceeded budget due to an increase in Emergency Department visits in May over budget estimates.

Scrubs purchased for the Emergency Department and maintenance supplies purchased by Engineering created a negative variance in Non-Medical Supplies.

Oncology Drugs Sold To Patients revenue came in below budget by 96%, creating a positive variance in Pharmacy Supplies.

Surgery, Medical Supplies Sold To Patients, and Laboratory supply costs fell short of budget creating a positive variance in Patient & Other Medical Supplies.

	MAY 2017	YTD 2017
Food	$ (3,236)	$ (14,597)
Office Supplies	(673)	(6,119)
Minor Equipment	(425)	(4,717)
Non-Medical Supplies	(4,247)	(4,617)
Imaging Film	166	1,508
Pharmacy Supplies	4,209	100,182
Patient & Other Medical Supplies	14,875	121,059
Total	$ 10,669	$ 192,699

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
MAY 2017

Note	Line Item	Variance from Budget Fav<Unfav> MAY 2017	Variance from Budget Fav<Unfav> YTD 2017
7) Purchased Services Physical Therapy and Medically Managed Fitness purchased services came in below budget, creating a positive variance in Miscellaneous.	Engineering/Plant/Communications	$ (427)	$ (31,058)
	EVS/Laundry	(2,988)	(30,805)
	Department Repairs	602	(13,833)
	Diagnostic Imaging Services - All	121	(2,185)
	Multi-Specialty Clinics	(95)	(927)
	Surgical Services	-	-
	Pharmacy	307	1,475
	Foundation	749	1,650
	Miscellaneous	2,663	16,107
	Laboratory	(1,797)	26,534
	Total	$ (866)	$ (33,042)
8) Other Expenses Advertising and Sponsorships for the Foundation created a negative variance in Marketing.	Insurance	$ (1,872)	$ (20,617)
	Marketing	(1,984)	(10,272)
	Dues and Subscriptions	131	(9,825)
	Equipment Rent	(237)	(5,674)
	Physician Services	-	-
	Multi-Specialty Clinics Equip Rent	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Other Building Rent	72	288
	Outside Training & Travel	(313)	1,080
	Utilities	(413)	20,062
	Miscellaneous	142	29,759
	Total	$ (4,474)	$ 4,802
9) Donations	Total	$ -	$ 24,267
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ 54,609

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2016	BUDGET FYE 2017		PROJECTED FYE 2017	ACTUAL MAY 2017	BUDGET MAY 2017	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	ACTUAL 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 16,129,087	$ 8,354,249		$ 17,027,755	$ 1,056,303	$ 125,378	$ 930,925	$ 4,905,089	$ 4,482,756	$ 4,632,586	$ 3,007,324
Interest Income	163,091	249,285		361,479	-	-	-	70,617	85,905	96,447	108,511
Property Tax Revenue	6,120,208	5,682,000		6,491,203	2,541,701	3,608,748	(1,067,047)	345,312	94,001	3,510,190	2,541,701
Donations	668,318	1,023,000		803,579	63,502	96,000	(32,498)	211,916	53,794	205,600	332,269
Debt Service Payments	(3,441,272)	(3,568,341)		(3,522,628)	(240,557)	(241,694)	1,137	(1,217,943)	(720,763)	(861,343)	(722,580)
Bank of America - 2012 Muni Lease	(1,243,650)	(1,243,644)		(1,243,649)	(103,637)	(103,637)	(0)	(310,912)	(310,912)	(310,912)	(310,912)
Copier	(8,758)	(11,520)		(11,526)	(1,188)	(960)	(228)	(2,885)	(2,656)	(2,878)	(3,108)
2002 Revenue Bond	(483,555)	(668,008)		(637,310)	-	-	-	(496,951)	-	(140,358)	-
2015 Revenue Bond	(1,705,309)	(1,645,169)		(1,630,144)	(135,732)	(137,097)	1,366	(407,195)	(407,195)	(407,195)	(408,560)
Physician Recruitment	(263,769)	(120,000)		-	-	-	-	-	-	-	-
Investment in Capital											
Equipment	(1,495,214)	(1,262,750)		(1,567,429)	(46,524)	(250,000)	203,476	(452,617)	(419,544)	(186,887)	(508,380)
Municipal Lease Reimbursement	1,319,139	979,000		735,082	-	-	-	-	-	-	735,082
GO Bond Project Personal Property	(432,135)	(279,000)		(1,174,396)	(2,503)	-	(2,503)	(532,573)	(364,495)	(174,438)	(102,890)
IT	(888,802)	(297,578)		(297,578)	(705)	(92,550)	91,845	(90,239)	(48,320)	17,785	(176,803)
Building Projects	(2,095,500)	(4,315,500)		(3,934,463)	(313,978)	(695,016)	381,037	(1,630,513)	(678,916)	(535,903)	(1,089,131)
Health Information/Business System	(92,807)	(7,000,000)		(4,434,396)	(254,568)	(950,000)	695,432	-	(2,051,447)	(553,064)	(1,829,885)
Capital Investments											
Properties	-	(2,794,000)		(2,802,193)	-	-	-	(40,000)	(2,333,193)	-	(429,000)
Measure C Scope Modifications	-	(2,476,716)		(1,679,157)	(219,802)	(324,468)	104,666	(558,626)	(261,384)	(69,361)	(789,786)
Change in Accounts Receivable	(1,194,734)	(2,183,288)	N1	(2,609,207)	1,268,667	463,264	805,403	(2,178,112)	(931,014)	106,152	393,766
Change in Settlement Accounts	1,387,101	1,175,000	N2	3,409,506	(525,432)	-	(525,432)	1,126,982	(205,102)	4,439,516	(1,951,890)
Change in Other Assets	(3,180,399)	(890,622)	N3	(1,564,859)	101,805	(1,032,748)	1,134,553	(687,607)	(1,034,847)	(372,202)	529,797
Change in Other Liabilities	3,702,607	(320,000)	N4	(1,772,801)	(518,577)	(1,100,000)	581,423	(2,392,808)	2,093	(1,370,595)	1,988,509
Change in Cash Balance	16,404,918	(8,045,261)		3,469,497	2,909,330	(393,086)	3,302,416	(3,121,122)	(4,330,475)	8,884,481	2,036,613
Beginning Unrestricted Cash	52,227,897	68,632,815		68,632,815	71,516,778	71,516,778	-	68,632,815	65,511,692	61,181,218	70,065,699
Ending Unrestricted Cash	68,632,815	60,778,463		72,102,312	74,426,109	71,123,692	3,302,416	65,511,692	61,181,218	70,065,699	72,102,312
Expense Per Day	340,958	355,605		361,779	361,882	355,155	6,727	352,658	353,874	359,049	361,779
Days Cash On Hand	201	171		199	206	200	5	186	173	195	199

Footnotes:

N1 - Change in Accounts Receivable reflects the 30 day delay in collections.

N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.

N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.

N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

15.3. Contracts

Contracts redacted.

Available for public viewing via a Public Records request.

Board Informational Report

By: Harry Weis **DATE: 6/13/17**
CEO

We are hoping for the final state licensure visit next week to obtain final approval to open our New Joseph Family Center for Women and Newborn Care!

We have really focused on our team in the past few weeks as we have held 18 Employee Town Halls on multiple days where about 30 minutes of each session was sharing important updates on our health system and one hour was a focus on input and questions and answers from our employees. We have another Employee Town Hall and BBQ in Incline Village scheduled for June 23rd.

We also have two separate Volunteer and Auxiliary group luncheons this month to honor our great teams of volunteers in Truckee and Auxiliary in Incline Village. We really thank them for their invaluable service in our Health System!

Our entire team continues to be extremely busy on our Six Critical Strategies which are: Physician Service Line Makeover; New Electronic Health Record and related business software; New Master Plan which will be shared at the June Board meeting as well; our new Patient Navigation and Care Coordination Programs; our "Just do it" categories of further improvements in Quality, Patient Satisfaction, Financial performance and Compliance; and finally our ongoing efforts to develop deeper and wider friendships with the communities we have the privilege to serve. We truly have more strategies in progress at one time now than at almost any time in our 65 year history.

We are moving along on an affiliation journey with our OB/Gyn group in town to be completed this calendar year.

We are also actively recruiting Family Practice, GI, General Surgery, Urology, and Neurology. We continue to improve content and techniques to improve the speed and the quality of outcomes in our physician recruiting efforts. We are also looking at succession planning in OB.

Further, we are active at work on bringing to life Tahoe Forest Medical Group, our friendly professional corporation before September of this year.

One example of many in our "Just do it" strategy" involves tuning up all entities in our health system. We remain in active evaluation of how to improve service and performance in the Truckee Surgery Center, an OP facility here in the community in which we have a 51% ownership.

Also in this important "Just do it" strategy we are really increasing our focus on philanthropy as this source of cash flow to any sustainable health system is critical. We had a great recent Best of Tahoe Chefs event and we have a great fundraiser coming up in Incline Village later this month.

We really want to thank all of those donors here in the District and in Incline Village who show where their heart is, as people only invest or donate where their heart is really focused. This is a journey of trust we do not take lightly as a healthcare team! There are many, many competing interests out there and we believe that timely access to great healthcare is the most precious gift that exists on this earth and our team is focused on delivering such great timely care!

Recently, Ted Owens and I visited Washington D.C. and we will report out at the board meeting on both federal and state legislative changes that are of concern to us and all health systems across America. We propose that a thoughtful, inclusive discussion be had regarding “all participants” in healthcare, including the provider segment and the very large administrative segment which never touches a patient if we are ever going to be truly successful on policy change that will achieve improved quality, and access to healthcare and actually lower the cost or flatten the trend line of healthcare costs in America. We have a shared goal, but in nearly all cases the wrong areas are being looked at in hopes of achieving this shared goal!

We are happy to have two very strong back to back financial years and we need many more such years as our capital needs to serve our community better are enormous over the next several years!

We face both rewarding and challenging times in the years ahead!

Board COO Report

By: Judith B. Newland **DATE: June 2017**

Just Do It" – Demonstrate measurable improvements annually in both Quality and Patient Satisfaction.

Staff attended the Annual Employee Town Hall Meetings located in the Eskridge Conference Room at Tahoe Forest Hospital. These meetings included a presentation by Harry Weis, CEO with an overview on TFHS advocating for healthcare reform and our health system initiatives and the path forward, a brainstorming session with staff on how to improve the patient experience and a question and answer session with senior leadership. The sessions were 1.5 hours in length with 15 being held at TFH and one at IVCH.

Tahoe Forest Health System continues their commitment to providing the Perfect Care Experience for all individuals who receive services throughout the organization. For the month of June the service tip is to: *Answer the phone PROMPTLY, SMILE, STATE YOUR NAME AND DEPARTMENT.* We've learned from our Press Ganey patient satisfaction results that communication is an opportunity for improvement. Every employee has an opportunity to be proactive and work together to improve our patient satisfaction scores.

The California Department of Public Health, in communication with the Quality Department, has indicated that they anticipate the new Joseph Family Women and Newborn Care Center and Dietary area to be surveyed in June. The Quality Department is working closely with both departments and CDPH to schedule the survey.

Develop solid connections and relationships within the communities we serve.

The annual Incline Village Community Hospital Auxiliary Appreciation Luncheon was held on June 5tht^{h} at IVCH, the excellent catering was provided by TFHD dietary staff. The Auxiliary has contributed over $400,000 to the purchasing of equipment at IVCH since 1996.

The Incline Village Community Hospital Foundation (IVCHF) had a successful Donor Appreciation Open House the evening of on May 18th, 2017. The open house is a thank you to donors for their philanthropic contribution to IVCH. Mr. Harry Weis, CEO, was the guest speaker and a tour of the Incline Health Center was provided. The generosity of community member's donations enabled the changes to the second floor health center to be made.

Board CNO Report

By: Karen Baffone, RN, MS
Chief Nursing Officer

DATE: June 2017

Strategy Two: Choosing and implementing the correct new Electronic Health Record for our system that spans all physician, OP and IP services.

All of the nursing backfill of positions is underway. The division will implement a full time float pool that will serve to improve the adequacy of resources during the Epic Go-Live process. This will also allow for evaluation of the utilization of a float pool long term, in meeting the staffing needs of the organization.

The operational readiness for the Epic implementation continues to have all clinical areas on tract for a November 1st go-live. The training schedules have been released and final training schedules are being prepared and will be available the beginning of July.

Strategy Four: Developing and implementing a comprehensive Care Coordination Plan coupled with Patient Navigation for all patients that touch our healthcare system.

Care Coordination and Navigation: Care Coordination continues to expand with the most recent Orthopedic Care Coordination having approximately 60 patients. These patients have a more episodic coverage when compared to the Chronic Care Management program. Work with the Executive Director of the MSC to incorporate office area for this care coordinator into the Orthopedic building to facilitate a more integrated approach to our surgical joint replacements.

Perinatal Care Coordinator is Sue Train. Sue bring experience in providing both lactation services and other related perinatal services to this position. Her role will emulate that of the orthopedic care coordinator in ensuring that patients' needs are met during pregnancy.

An interim leader for Case Management has been be hired with a start date of July 7th. We have retirement within the department as well as onboarding of new case management staff. Case Management, Care Coordination, Utilization Review, Clinical Documentation Improvement, as well as Clinical Auditing will be integrated under one Director. This process will transition over the next six months.

Improved marketing of our Navigation program is under development with the Marketing department. Our goal is to incorporate our navigation program into the TFHD webpage as an initial strategy.

Board Informational Report

By: Jake Dorst **DATE: 6**-13-2017

CIIO

Mercy Epic

- Completed build spreadsheets for all new order sets. Mercy now building. Beginning work with Shawni Coll who will facilitate each physician specialty group OS review process to become familiar with Mercy OS.
- Many Order Sets will require a TFH preference version created where we save defaults and wording preferences for providers.
- Interface work is an enormous task. Working with many vendors.
- Clinical Analysts defining all workflows and any changes to current processes which is a big effort in all clinical areas.
- Order Sets: Need a process with Mercy for updates/changes post go live with timely notification for our committee review.
- Mercy currently building any Order Sets that were not able to be matched with existing Mercy order sets.
- Interface testing started with test channels.
- Identifying any documentation areas in Mercy Epic that change our practice and having webex reviews with appropriate TFH staff and leaders.
- Determining any areas in Mercy Epic build that need changes due to Title22/HFAP.
- Beginning work on Patient Education documents.
- Shadow testing of workflows in Optime and ASAP have started.
- Dr. Stacey Meredith assisting with all physician screens for ASAP. Defining quick order lists.

NantHealth

- Will be here week of 7/17 to test one fully set up anesthesia machine. PC must be imaged and NantHealth installed. (IT, Anesthesia and Clinical all testing together)

Epic Beaker Lab (Special recognition for Gina Watson. We are very lucky to have her for this project)

- Quest (Reference Lab) Testing interfaces. Test compendium build underway.
- Aurora Western Pathology: Completely new for us. We have never had a Path interface. Build almost complete. Testing orders/results messages.
- Mediware Blood Bank: Completely new for us. We were on paper. Build complete. Validation testing beginning. This has to be validated by a third party independent also.
- Varian: Requires new compendium build in Varian for all lab results. Testing interfaced results next week.

GE Centricity for Fetal Monitoring project has begun.

- Project is underway. Servers built. Working on interfaces with Mercy.
- Perinatal Web: Will have doctors coming through Citrix to our network and then getting the web app.
- Training for nursing will be combined with Epic training requiring special training room set up

Aperek

- Pulse Appliance installed for data extract transport

Data Extract Files

- All current data extract files that go to agencies, vendors etc. have been defined. Each of these has to be rebuilt with Mercy Epic. The specs of each have been and the build is starting.

Downtimes

- Many downtimes for IP updates and infrastructure work. Impacts clinical areas each time. Everyone is pitching in and managing. Clinical Analysts have been great for supporting the downtime planning and recovery post downtime.

Board Informational Report

By: Shawni L. Coll D.O., FACOG
Chief Medical Officer

DATE: June 15, 2017

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1. **GOAL: A complete makeover of our Physician service line**
   We have signed Letter of Intents with the three physician's from Tahoe Forest Women's Center and plan to bring them into the MSC this Fall. We have been actively recruiting for a fourth Ob/Gyn to add to the group so that Drs. Taylor and Coll may share a full time equivalent position. We have interviews set up for both a permanent urology and permanent gastroenterologists this month. We are also deep into contract renewals for some of our physicians.

2. **GOAL: Electronic Health Record**
   We are working with the medical staff to prepare for new process changes and implement workflow changes now so that at Go Live, these changes will be ingrained already.

3. **GOAL: New Master Space Plan**
   We have been working closely with our architect to develop interior footprint designs for the second floor of the cancer center. These options will be vetted with the financials to decide the most functional and cost efficient space. It should be noted that the lack of available space in the clinics is limiting the growth of current and potential service lines.

PURPOSE:

This policy ~~is intended to provide the~~provides Tahoe Forest Hospital District's Chief Executive Officer ("CEO") a ~~general~~ framework for professional services contracting ~~and recognizes~~to ensure ~~that flexibility may be required due to the broad scope of~~the professional ~~services that may be covered. Further, to insure that the professional~~ service provider ~~is meeting~~meets the needs of Tahoe Forest Hospital District ~~and IVCH~~ ("TFHD" or "District") and the communit~~y~~ies that it serves. ~~, as well as allowing the provider to update the actual services performed, a formal service review process will be utilized.~~

POLICY:

Written professional service agreements will be prepared for all ~~physicians, physician groups, and~~ health professionals who qualify as independent contractors and ~~who~~ provide diagnostic or therapeutic services to TFHD's patients~~,~~ or ~~who~~ provide certain medico-administrative duties within a hospital department or service.

The following ~~list exemplifies~~ ~~physicians, physician groups, and~~ health professionals ~~who will be~~are covered by this policy ~~including~~ ~~, but not limited to~~:

- Anesthesiologists
- Medical Directors ~~of specific departments/services, and~~
- Medical Staff ~~Officers~~ officers
- Physicians providing services in the District's ~~Medical Services~~Multi-Specialty Clinics, Cancer Center or other professional practice settings operated by TFHD (collectively, "TFHD Practice Settings").
- Physicians serving in medical-administrative roles or on District committees
- Nuclear Medicine ~~Specialists~~ specialists
- Emergency Services physicians
- Occupational therapists
- Pathologists
- Physical therapists
- Radiologists
- Speech pathologists
- Emergency and urgent care providers
- Mid-level practitioners not employed by the District
- Hospitalists
- Other contracted ~~physicians~~ health or medical service providers

PROCEDURES:

~~A.~~1. All professional service agreements will be developed between the ~~District's Chief Executive Officer~~CEO~~,~~, or the CEO's designee, and the health professionals.

   ~~1.~~1.1. Health professionals are not permitted to provide professional services ~~under any professional services agreement~~ until ~~the~~an agreement has been approved by the ~~Board of Directors~~District prior to the agreement effective date. Signatures will be obtained prior to the agreement effective date or in accordance with current Stark Law. Agreements containing amendments to the terms and conditions of the agreement must also be executed prior to the effective date and prior to the provision of professional services under the amended agreement.

~~2.~~1.2. New and renewal agreements shall utilize the template agreement for the type of service required from the contracting professional (See Exhibit A, attached, for a list of available model agreements.)~~; and~~

~~a.~~1.3. All agreements shall be reviewed by the Compliance Department. ~~New~~ Aagreements not utilizing the template agreement ~~for the type of service required~~ shall also be reviewed by ~~the Compliance Department and~~ legal counsel.

~~b.~~1.3.1. Agreements committing $~~25~~400,000.00 or more in any ~~given~~ twelve-month period:

~~i.~~1.3.1.1. Once agreement is reached between the ~~District's Chief Executive Officer~~CEO and health professional, CEO will ~~place~~present the provider-signed ~~the~~ professional services agreement ~~on~~to the Board of Directors ~~agenda and present~~with the Contract Routing Form (or equivalent data summary report) with ~~the~~ principal terms and conditions ~~listed, and agreement to the Board of Directors~~ for their consideration. Principal terms and conditions include, but are not limited to, justification ~~for the agreement~~, ~~agreement~~ term, compensation, scope of duties, total cost of contract, and other pertinent information, as applicable~~, in 6.2-6.4 below~~.

~~ii. All agreements and amendments completed at least five (5) days prior to the designated Committee meeting will be reviewed by a Board Committee, as designated by the By-Laws or the Board of Directors .~~

~~iii. The designated Committee will review agreements and make recommendations to the full Board of Directors.~~

~~iv. The District's Chief Executive Officer will place the agreement on the agenda of the District Board of Directors for their consideration.~~

~~v.~~1.3.1.2. Upon ~~their~~ review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions~~,~~ or direct a designated ~~b~~Board committee to review and make a recommendation to the Board of Directors ~~and revised terms and conditions be submitted to the Board at its next scheduled or special meeting~~.

~~vi.~~1.3.1.3. Board ~~After approval by the Board of Directors, the CEO will present the agreement to the health professional for review and signature, indicating his or her acceptance of the included terms.~~ ~~A~~approval of a professional services agreement constitutes direction to ~~by the Board of Directors directs the~~ CEO to execute the professional service agreement.

~~vii. In the rare event the health professional requests changes in the principal terms and conditions of the agreement, the CEO will present a modified Contract Routing Form (or equivalent) and agreement to the Board of Directors. The CEO will execute the agreement after approval by the Board of Directors.~~

~~viii. The professional service agreement will become effective following the Board of Directors' approval, subject to the contract term identified in the agreement.~~

~~c.~~1.3.2. ~~New and renewal a~~Agreements committing less than $~~25~~400,000 ~~per~~ in any twelve-month period ~~can~~ may be authorized by the ~~District's~~ C~~hief~~ E~~xecutive~~ O~~fficer~~ without Board approval ~~so long as~~ when funds have been ~~authorized~~ appropriated in the District's operating budget for ~~that~~ the fiscal year.

~~Physician and other p~~Professional service agreements due for renewal may be held over for up to twelve months with no change in terms at the discretion of the CEO~~,~~ and in accordance with the Stark Law and applicable regulations. Note: ~~the~~ Stark Law regulations currently permit unlimited holdover of physician professional service agreements ~~as long as~~when the contract stays within the Fair Market Value.

1.4.

~~3.~~ Urgent Services:

~~a.~~ At the discretion of the CEO, a~~n~~ professional service agreement required for urgent services may be executed if a quorum for a Special Meeting ~~presented directly to~~of the Board of Directors cannot be assembled.

~~b. All terms and conditions must be included at the time of presentation.~~

~~4. All physician and professional service agreements will be processed by the Chief Executive Officer's administrative staff. The following guidelines will be utilized:~~

a. Material and checklists (provided in AGOV-10 Contract Review Policy) for agreements will be presented to the Chief Executive Officer's administrative staff in a timely manner to ensure that adequate time is available for preparation of the agreement within the required time frames for timely execution and implementation.

b. Content and negotiations with health service professionals will remain the the responsibility of the Admin Council members.

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B.2. Compensation under Professional Service Agreements (PSA) With Physicians Only

2.1. In all cases, theNew and renewal agreement will specify the financial arrangements related to the provision of physician professional services.

2.1.1. In no case shall compensation to physicians take into account -the volume or value of anticipated or actual referrals physician's make to TFHD or IVCH. TFHD shall endeavor to maintain a flexible approach with physicians within a specialty and among various specialties or TFHD or IVCH Practice Setting, irrespective of referrals to TFHD or IVCH generated, by an individual physician or the type of specialty or the TFHD/IVCH Practice Setting. The following methodologies may be utilized:

2.1.2. Management shall endeavorstrive to create a model that is aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.

2.1.2.1. Pay within constraints of fair market value

2.1.2.2. Maintain internal equity within and between specialties

2.1.2.3. Provide sufficient compensation to recruit and retain physicians

2.1.2.4. Encourage quality and productivity

2.1.3. Be Cclear and understandable to all parties

The methodologies in this section 2 may be utilized to determine compensation with physicians.

1.2.2. Hourly rates. Hourly rates are the preferred compensation method for administrative duties such as medical directorships, -preceptor, -medical staff leadership positions, or committee attendance, and may also be used when clinical and administrative duties are combined. Hourly rates or "per shift" rates with hours of coverage and response time specified are the preferred compensation method for on-call and hospitalist coverage.

2.2.1. Physicians shall be required to document and attest to the date, hours worked or shifts covered. spent, and

a.2.2.2. In addition, a description of work completed or meetings attended shallwill be provided for all administrative duties.

b. On call calendars maintained by the medical staff office may be utilized as documentation for on-call and hospitalist agreements.

2.3. Rate per unit of production. The Rate per Work Relative Value Unit (WRVU) is the preferred measure of physician productivity and should be used as the unit of production whenever feasible. Payment at a set rate per Work Relative Value Unit (WRVU) is an additional the preferred compensation method for multi-specialty clinic (MSC) physicians providing professional medical services under a professional service agreement in a TFHD Practice Setting, who are working full-time or less, and may also be utilized for other physicians when mutually agreed upon by the parties.

2.3.1. The preferred source for establishing the rate per WRVU shall be a three-year average of the Nnational median ratio of compensation to WRVUs published in the MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches that yield fair market value compensation may be substituted based upon the circumstances of the negotiation.based on the

~~same compensation and production survey data that is utilized for physicians working half time or more, and may include an allowance for malpractice and benefits.~~

2.3.2. An alternate measure of productivity such as visits may be used as deemed necessary by management.

~~2.~~2.4. Base compensation plus bonus. Payment of a fixed base compensation plus bonus is ~~one~~ another acceptable compensation method for physicians who are providing professional medical services, ~~more than~~ half time or more, under a PSA in a TFHD Practice Setting. This methodology may be utilized for newly recruited physicians during the start-up phase (generally a year), for physicians in specialties where community demand is insufficient to support a full-time practice, or in other situations in which such method is needed for physician retention.

~~a.~~~~1.1.1. Management shall endeavor to create a model that is aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.~~

~~i.1.1.1.1. Pay within constraints of fair market value~~

~~ii.1.1.1.1. Maintain internal equity within and between specialties~~

~~iii.1.1.1.1. Provide sufficient compensation to recruit and retain physicians~~

~~iv.1.1.1.1. Encourage quality and productivity~~

~~v.1.1.1.1. Be Clear and understandable to all parties~~

~~b.~~2.4.1. Base compensation shall be established based on an agreed upon percentage of the median compensation from one or more published compensation surveys~~, adjusted for the physician's FTE status~~.

~~i.~~2.4.1.1. Base ~~Compensation~~ compensation is defined as compensation prior to inclusion of compensation related to benefits/benefits allowance, excess ED On-call services, or administrative medical services.

~~ii.~~2.4.1.2. FTE status shall be based on agreed number of days of work and/or hours of clinical availability, which may vary by specialty but which shall be consistent within each specialty.

~~iii.~~2.4.1.3. The ~~survey to be utilized~~preferred source for establishing base compensation shall be the three-year average of the ~~N~~national median compensation published in the ~~annual~~ MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches to yield fair market value compensation may be substituted based on the circumstances of the negotiation.

~~iv. The Western Region median may be utilized.~~

~~v. Data shall be smoothed by utilizing a 3-year average of the median from the three most recently published surveys.~~

~~vi. In the event that, in management's professional opinion, the data from the MGMA survey in the Western Region is unreliable due to the low number of respondents or other factors, management may utilize the national median and/or data from other published surveys.~~

~~vii. Survey data shall be adjusted for inflation that has occurred since the data was collected.~~

~~viii.~~ The percentage of median may be ~~adjusted~~ established based on the physician's FTE status, historic productivity, years of experience, special expertise, or the difficulty of recruiting a particular specialty to the area. ~~However:~~

~~a. In no case shall the percentage of median compensation paid as Base Compensation (before FTE adjustment) exceed 130% of the MGMA median.~~

~~b. Physician's Base Compensation may be adjusted once per year if: Physician's FTE status has changed or for market changes.~~

2.4.1.4. ~~Physician's prior year productivity has fallen below 90% of the prior year's target, and physician failed to reach this productivity level due to factors that are under the physician's control, such as leaving early or taking excessive time off. Determination of the reasons for any such failure shall be reviewed by a panel that includes the Executive Director of Physician services (or designee), the Medical Director of the Department, and at least one other physician.~~

2.4.2. A production-based bonus may be offered in addition to base compensation ~~in order~~ to encourage physician productivity.

2.4.2.1. Production shall be measured in WRVUs whenever possible.

2.4.2.2. A production target shall be established, and the production-based bonus shall be paid, only for production in excess of the established target.

2.4.2.3. A rate per unit of production shall be established as described above.

~~e.~~2.4.2.4. The preferred method for establishing the production target shall be dividing the rate per unit of production into the base compensation, provided however that the physician's cost of benefits and malpractice insurance may be considered in the calculation.

~~e.~~2.5. Malpractice insurance and benefits. The costs of malpractice insurance and benefits that are borne by the physicians shall be considered based on such reasonable methodology as may be developed by management, which may include but is not limited to:

2.5.1. ~~Adding the~~ Providing a fixed benefit allowance based on the estimated costs of malpractice insurance, health insurance, retirement benefits, employer-paid payroll taxes, and other benefits that are customarily paid by organizations with the ability to employ physicians.

~~i.~~2.5.2. Increasing the rate per WRVU or other unit of production on a percentage basis to account for such malpractice and benefit costs.

~~ii.~~2.5.3. Reducing the WRVU target by an amount that would enable physicians to earn all or a portion of those costs by reaching a production level that is commensurate with their compensation.

~~d.~~2.6. Quality Incentive. Physician contracts may include a ~~production and/or~~ quality incentive, ~~to encourage physicians to work to their full capacity,~~ provided:

~~i. Productivity is measured in Work Relative Value Units (WRVUs), unless physician works in a specialty for which WRVU benchmark data is either unavailable or insufficient, in which case an alternate measure such as visits may be utilized.~~

~~ii. The production incentive does not take into account the volume or value of anticipated or actual referrals of Tahoe Forest Hospital District OR IVCH facilities.~~

~~iii. The production target is set based on the same survey benchmarks utilized for compensation, and is set at a level that is proportionate to base salary.~~

~~iv.~~2.6.1. Quality incentives, if any, are measurable and linked to factors that are within the physician's control.

~~v.~~2.6.2. The total projected compensation, including incentives, does not exceed fair market value.

~~3.1.1. Rate per Work Relative Value Unit (WRVU). Payment at a set rate per Work Relative Value Unit (WRVU) is an additional compensation method for multi-specialty clinic (MSC) physicians who are working full-time or less, and may also be utilized for other physicians when mutually agreed upon by the parties.~~

~~a.1.1.1. The rate per RVU shall be based on the same compensation and production survey data that is utilized for physicians working half-time or more, and may include an allowance for malpractice and benefits.~~

~~4. Percentage of professional fee collections. Payment based on a percentage of professional fees collected may be utilized for physicians in those instances where the District accepts responsibility for billing and collecting from the patient or any third party payer for professional services and is able to separately bill for professional service fees.~~

~~a. Remuneration based upon a percentage of combined facility and professional gross charges or collections is prohibited.~~

~~b. The District will remit the amounts collected, depending upon the agreement, to the physician, deducting a percentage to account for the estimated expenses of the District's billing and collection services and other administrative and support services, if provided.~~

~~c. If the payment to the healthcare provider is based upon billings rather than collections, a further percentage will be deducted so to account for the estimated incidents of bad debts and contractual allowances. Furthermore, if the payment to the healthcare provider is based upon billings rather than collections, a revenue collection analysis will be performed at least annually~~

~~to ensure compliance to the above compensation provision.~~

~~d. All professional fee schedules shall be made a part of the agreement and appropriately referenced. Professional fee schedules may be revised annually. Any changes to the professional fee schedule must be discussed between the District Chief Executive Officer and requesting physician prior to becoming effective. Requests shall conform to the following criteria:~~

~~i. Should provide sufficient detail to fully describe the professional services, relevant billing code numbers and professional fees;~~

~~ii. All professional fees shall be reasonable and customary and comparable to professional fees charged by their peers within our region. The mechanism for determining compliance to this criteria will be determined on a case by case basis between the professional provider and District Chief Executive Officer.~~

~~iii. Other relevant information should also be provided, e.g., changes required as a result of regulatory mandates; requests from individual physicians and Medical Staff; new service charges or extraordinary changes in provider costs not previously anticipated.~~

~~iv. Written agreement reflecting mutual acceptance of the proposed revisions as meeting the above criteria shall be required prior to the changes becoming effective.~~

~~5.~~2.7. Payment per service. Payment at a specified rate per service is a permitted method for limited scope agreements in which the physician is providing clearly delineated clinical services. Examples include EKG interpretations, audiology reviews, and other services that are billed on a global basis by the hospital.

~~6.~~2.8. Specialty call activation fee. In specialties where a regular on-call panel is either infeasible due to the number of physicians on the medical staff within that specialty or the low incidence of emergency need for that specialty, a specialty activation fee may be offered in the event that physician is called in to respond to an emergency.

~~7.~~2.9. Fair Market Value. In all cases, physician's total compensation must be within fair market value and must be determined to be commercially reasonable.

~~a.~~2.9.1. Fair market value for any individual contract shall generally be defined as an amount equal to or less than the 75th percentile of fair market value compensation, considering the physician's FTE status and production levels.

~~b.~~ However management shall endeavor to design a compensation model that maintains the average physician's compensation between the 40th and 60th percentiles, based on the ~~survey referenced in B.2.b.iii above~~MGMA Physician Compensation and Production Surveys.

2.9.2.~~-~~

~~C.~~3. Multiple ~~A~~agreements

~~1.~~3.1. Nothing in this policy shall prohibit TFHD from entering into multiple agreements with ~~physicians~~health professionals~~;~~, provided ~~however that~~ the designated hours~~/~~ and types of service are clearly segregated.

~~a.~~3.1.1. Physicians whose professional duties under a PSA are ~~typically~~ during regular Monday through Friday daytime hours may ~~be paid~~ have a separate agreement for on-call coverage during evenings, weekends, and scheduled days off and/or for administrative duties performed during lunch or after regular clinic hours.

~~b.~~3.1.2. Physicians working in a TFHD Practice Setting who provide hospitalist, on-call, or administrative services during normal scheduled clinic time shall receive WRVU credit in lieu of cash payment.

~~The~~ A physician may perform administrative duties while on call, as long as clinical duties are not needed. If ~~the~~ a physician is needed for clinical duties, they may not bill administrative time when performing clinical duties.

3.1.3.

~~c.~~ Fair market valuations shall take into account the existence of multiple agreements with one contracting ~~professional~~physician.

~~d. The multiple agreements of a contracting professional shall be referenced in each of the agreements with that contracting professional.~~

3.1.4. -

~~D.~~4. Physician Qualifications

~~1.~~4.1. Professional service agreements with physicians shall require:

4.1.1. A valid and unrestricted license to practice medicine in the state issued by the applicable state Medical Board;

~~a.~~4.1.2. Physician must achieve Board certification when eligible and/or maintain Board certification.

~~b.~~4.1.3. The ~~contracting~~ physician is not suspended or excluded from participating in any federal health program;

~~c.~~4.1.4. All appropriate certifications, registrations and approvals from the Federal Drug Enforcement Administration and any other applicable federal or state agency necessary to prescribe and dispense drugs under applicable federal and state laws and regulations, in each case without restriction;

~~d.~~4.1.5. Prompt disclosure of the commencement, resolution or ~~pendening~~pend~~ing~~ency of any action, proceeding, investigation or disciplinary proceeding against or involving ~~Physician~~physician, including, without limitation, any medical staff investigation or disciplinary action;

~~e.~~4.1.6. Prompt written notice of any threat, claim, or legal proceeding against TFHD ~~or IVCH~~ that ~~Physician~~ physician becomes aware of, and ~~cooperate~~ cooperation with TFHD in the defense of any such threat, claim, or proceeding and in enforcing the rights (including rights of contribution or indemnity) that TFHD may have against other parties or through its insurance policies;

~~f.~~4.1.7. No discrimination against a patient based on race, color, creed, religion, national origin, gender, sexual orientation, disability (including, without limitation, the condition(s) for which the patient seeks professional services from ~~Physician~~physician), marital status, age, ability to pay or payment source, or any other unlawful basis.~~.~~

~~2.~~4.2. Physician Qualifications In Coordination With Medical Staff Bylaws:

~~a.~~4.2.1. Professional service agreements with physicians shall require their membership on the respective hospital's Medical Staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

~~b.~~4.2.2. Termination of the agreement will cause the physician to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the physician would lose ~~his~~ Medical Staff membership and privileges; he/she would simply lose the right to gain access to the service or department which is the subject of the exclusive agreement.

~~3.~~4.3. Contract Termination Clause

~~a.~~4.3.1. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon prior written notice.

~~b.~~4.3.2. The following language will be utilized:

~~i.~~4.3.2.1. "For cause" termination of a physician contract at any time during the- term;

~~ii.~~4.3.2.2. "No cause" termination during the initial or subsequent- term. In the event a "no cause" termination occurs during the first year of the agreement, the parties may not enter into a new agreement for substantially the same services until after the expiration of the initial one-year term of the agreement.

~~iii.~~ The time-frame for prior written notice may range from 60-180 days. Further, termination of the agreement does not afford the physician the right to request a medical staff hearing or any other review ~~pursuant to~~under the Medical Staff By-Laws or rules and regulations, based on termination of the agreement.

4.3.2.3. -

~~E.~~5. Provisions For Non-Physician Health Professional Service Agreements

~~1. Compensation:~~

5.1. In all cases, the contract will specify the financial arrangements related to the provision of professional services. It is desirable that remuneration be based upon a set professional fee schedule rather than a percentage of gross or net patient charges. However, it is recognized that a wide variety of other mechanisms may be utilized and such other mechanisms are left to the discretion of the ~~District Chief Executive Officer~~CEO and Board of Directors.

~~2.~~5.2. Compensation for health professional service agreements shall not exceed fair market value of the services.

~~3.~~5.3. Professional Fee Schedule

~~a.~~5.3.1. When reimbursement is based upon professional fee schedules, ~~said~~ the fee schedule ~~shall~~ will be made a part of the agreement with the health professional. When provided for by agreement, professional fee schedule revisions will be considered once annually in a time-frame that coincides with the District's operating budget.

~~i.~~5.3.2. Requests for revisions ~~must~~ should be submitted to the ~~District Chief Executive Officer~~CEO by April of each year for implementation by July. The request should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees requested. The ~~District Chief Executive Officer~~CEO ~~will~~ determines whether ~~the acceptability of~~ the proposed changes are acceptable.

~~4.~~5.4. Health Professional Qualifications in Coordination with Medical Staff By-Laws:

~~a.~~5.4.1. Professional service agreements may require certain health professionals to be members of the District's allied health professional staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

~~b.~~5.4.2. Should a health services agreement be cancelled involving an allied health professional, termination of the agreement will cause the health professional to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the health professional would lose ~~his~~ allied health professional appointment or related privileges.

~~5.~~5.5. Contract Termination Clause

~~a.~~5.5.1. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon written notice.

5.5.2. The timeframe for prior written notice may range from 60-180 days. When the health professional is required to be an allied health professional, termination of the agreement will not afford the allied health professional the right to request ~~the~~ a due process hearing ~~described by the~~under any Medical Staff bylaw, rule,s ~~and~~ or regulations for allied health professionals, based on termination of the agreement.

~~b.~~ In all cases, professional service agreements will provide for termination "for cause" at any time during the contract term.

5.5.3. -

~~F.~~6. Physician and Health Professional Service Agreement Contract and Service Review

~~1. Contract Review~~

~~a. Prior to the end of a contract period, the Chief Executive Officer, or designee, may choose to conduct a contract review or at any time during the contract period.~~

~~b. The Board of Directors can recommend that a contract review be done prior to most contract renewals but allows the CEO discretion to fore-go the review if the contract renewal is on an annual basis or if other factors indicate that the review is not necessary prior to that particular contract renewal.~~

~~c.~~ At a minimum of every five years, the C~~hief~~ E~~xecutive~~ O~~fficer~~ or CEO's designee will conduct a service review of the contract service provided by the physician, physician group and/or other professional service. ~~The Chief Executive Officer will undertake the service review and a report based upon this service review will be made to the Board of Directors.~~

~~A. Contract Review Elements~~

~~1. Analyze the continuing need for the services covered by the contract.~~

~~2. Ensure that the terms of the contract are being met as outlined in the service agreement.~~
~~3. Review the service as it related to consistency with the District's compliance program.~~
~~4. Assessment of patient, physician and staff opinions/input/complaints.~~
~~B. Service Review Elements~~
~~1. As part of the service review, the Chief Executive Officer will request feedback from the medical and clinical staff regarding the following:~~
~~a. Quality of care being provided based on the specialty's identified standards of care.~~
~~b. Availability and responsiveness.~~
~~c. Consistency with the District's compliance program.~~
~~d. Patient, physician and staff opinions/inputs/complaints~~

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~~C. Other Review Elements~~

~~In addition the Chief Executive Officer will:~~

~~1. Ensure that the terms of the contract are being met as outlined in the service agreement.~~
~~2. Review market conditions with appropriate benchmarking and response to changes in the marketplace, and make recommendations as to the continuation of the current contract.~~
~~3. Seek a fair market valuation via written opinion of an experienced professional valuation expert, for any agreement, for the same specialty/scope of services, where the previous valuation was completed more than two years prior to the anticipated renewal date.~~
~~4. Document the community need for the physician or other healthcare professional services provided under the agreement.~~
~~5. Document how the agreement furthers specific strategic, business or operational goals of the District, increases integration of services, avoids costs/reduces expenses that would otherwise be incurred by the District, or furthers needed research and development within the District.~~
~~6. Evaluate the use of less expensive alternatives.~~
~~7. Ensure that the fee schedule is appropriate for current market conditions.~~
~~8. Take in to consideration elements of the contractor's relationships with service providers, the District and the community.~~
~~9. Review standards and best practice recommendations set by professional and specialty organizations with appropriate consideration of our community and Hospital District.~~

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~~D. The Chief Executive Officer will compile a report based upon the service review and present it to the Board of Directors with recommendations related to continuation of the contract or consideration of a Request For Proposal (RPF) process.~~

6.1. -

General Contract Inclusion Terms:

~~A.~~7. ~~General Provisions:~~ Physician and Health Professional Service Agreements

~~1.~~7.1. Professional Service Duties and Responsibilities: Each agreement will include a detailed and specific delineation of the duties and responsibilities to be performed by the health professional as well as the District. For example, extensive detail will be provided regarding:

~~a.~~7.1.1. Diagnostic and therapeutic services to be provided
~~b.~~7.1.2. Medico-administrative services to be provided
~~c.~~7.1.3. Coverage obligations to be assumed
~~d.~~7.1.4. The rights and obligations of the District and the health professional with regard to

providing space, equipment, supplies, personnel and technicians.

~~2.~~7.2. Standards ~~Of~~ of Practice: Each agreement shall specify that the health professional will provide the service in accordance with the Hospital Bylaws; Medical Staff Bylaws, Rules and Regulations, and if applicable, standards established by the Executive Committee of the Medical Staff; ~~with the ethical and professional standards of the American Medical Association and the California and/or Nevada Medical Association; the standards of the Healthcare Facilities Accreditation Program (HFAP) and in any applicable specialty college or society or governmental regulation.~~

~~3.~~7.3. Medicare and Medicaid Enrollment: Each agreement shall specify that the health professional is duly enrolled in the federal Medicare program and the applicable State Medicaid program (unless excepted by the District) and eligible to seek reimbursement under such programs for covered services rendered by the provider to beneficiaries of such programs. Every agreement must contain a provision in which the health professional agrees to notify ~~TFHS~~ TFHD in the event participation terminates.

~~4.~~7.4. Quality Assessment: Professional service agreements shall require the health professional to participate in the Health System ~~,~~Quality Improvement Program to ensure that the quality, safety and appropriateness of healthcare services are monitored and evaluated and that appropriate actions based on findings are taken to promote quality patient care. Furthermore, each agreement shall specify a process designed to assure that all individuals who provide patient care services under service agreements, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services. Whenever possible, information from customer satisfaction surveys shall be incorporated into the Quality Improvement Program for ~~said~~ the service. Agreements which provide for Directorship responsibilities over a department or service shall require the health professional "Director" to be responsible for implementing a monitoring and evaluation process designed to improve patient care outcomes and which is integrated with the Health System Quality Improvement Program.

~~5.~~7.5. Assignability: It is desirable that all professional service agreements be non-assignable unless important to the successful negotiation of a contract where higher priority objectives may be achieved. Where assignability becomes necessary, assignability shall be allowed only with the condition that prior written consent of the ~~Board of Directors~~District be obtained.

~~6.~~7.6. Contract Term: Professional service agreements shall specify an effective date that is later than all requirements, including credentialing, being met. ~~specific term and termination date (i.e., not automatically renewable for successive years).~~ In considering the term of the agreement, the termination date of related agreements should be considered by the ~~District Chief Executive Officer~~CEO so as to minimize the likelihood of multiple agreements coming due on the same date or year. The length of the term shall be negotiable. Professional service contracts will typically range from one to four years in duration.

~~7.~~7.7. Professional Liability: In all cases, the health professional will be responsible for providing adequate professional liability insurance coverage at the health professional's expense. Limits of coverage for physicians will be a minimum of $1,000,000 per occurrence, $3,000,000 aggregate. For non-physicians, the minimum limits of coverage may vary depending on the standard established for that health profession in consultation with the District's risk manager. The agreement shall also specify that the contracting health professional will, in turn, either require or arrange for professional liability insurance coverage for all sub-contracting health professionals. Furthermore, the professional liability insurance policy must be obtained from a professional liability insurer which is authorized to transact the business of insurance in the State of California (or Nevada in the case of professional services provided at the District's ~~Community Hospital in Incline Village,~~ Nevada-based facilities). Also, the professional services agreement must require that the selected insurer will be responsible for notifying the District of any cancellation or reduction in coverage within thirty days of ~~said~~ such action.

~~8.~~7.8. Regulatory Compliance: The agreement should include provisions in which both the District and the health professional commit to full compliance with all federal, state, and local laws. The contracting party should agree to keep confidential any financial, operating, proprietary, or business information relating to the District and to keep confidential, and to take the usual precautions to

prevent the unauthorized use and disclosure of any and all Protected Health Information. The agreement should include provisions for amendment to the agreement in furtherance of maintaining compliance in the event of the adoption of subsequent legislation and/or regulations.

~~9.~~7.9. Recitals: Exclusive professional service agreements should include a carefully developed description of the rationales for exclusivity in a particular clinical service or department. Furthermore, if the agreement does assign exclusive responsibility for a particular service, it should state so expressly not leaving this to inference or interpretation.

~~10.~~7.10. Professional Relationships: The agreement should specify that the health professional is an independent contractor and is not an employee of the District.

~~11.~~7.11. Government Audit: The agreement should include the standard provision recognizing that the agreement and certain other materials will be subject to audit and inspection by certain federal authorities with regard to payments made for Medicare services.

~~12.~~7.12. Standard Contractual Language: The agreement should include certain standard provisions to the effect that the provisions of the contract are severable and, therefore, the ruling that any one of them is void does not invalidate the entire agreement, and that the waiver of breach of one provision does not constitute a continuing waiver, and that the written agreement constitutes the entire contract between the parties.

~~13.~~7.13. Managed Care: The physician or health professional agrees to participate as a preferred provider with all of the managed healthcare plans (PPOs and HMOs) that the District has agreements with including agreements with insurance companies, health maintenance organizations and direct contracting with self-funded employers. Any deviation of this policy must be approved by ~~District Administration~~the CEO and the Board of Directors.

EXHIBIT A

No.	Contract Title	Last Date Modified
1	Call_Coverage_Agreement_Template_Individual_2015 **(version dated 8/11/14 does not have Master List provision)**	**3/30/2015**
2	Call_Coverage_Agreement_Template_Medical_Group_2015	4/16/2015
3	Confidentiality_Nondisclosure_Agreement_2015	3/25/2015
4	EKG_Letter_Agreement_Template_2014	10/29/2014
5	Non-Physician_Consultant_Agreement_Template_2014	9/25/2014
6	Hospitalist_Services_Agreement_Template_2014 **(Template has Master List provision Paragraph 2.4)**	**8/13/2014**
7	Interim_Physician_Designee_Contract_2014 **Version dated 02/23/2015 for Dr. Standteiner does not have Master List provision; add after 12. Governing Law)**	10/30/2014
8	Medical_Director_Agreement_Individual_2014 **(Dr. Tirdel's Med Dir of ICU & RT version on 2/23/15 has paragraph 11.3)**	**8/13/2014**
9	Medical_Director_Agreement_Medical_Group_2015	6/26/2015
10	MSC_PSA_Template_2014 **(Template has Master List provision Paragraph 2.5)**	8/13/2014
11	Retention_Agreement_Template_2015	4/23/2015
12	Recruitment_Agreement_Template_Co-obligors_2015 **(No Master List provision; add to VII Miscellaneous)**	**2/20/2015**
13	Recruitment_Agreement_Template_Physician-obligor_2015	**2/20/2015**

(No Master List provision; add to VII Miscellaneous)

14	Rural_Prime_Site_Preceptor_Template_2015	4/30/2015
15	TF2020_Agreement_for_Medical_Advisor_Services_2015	4/3/2015

This list was last updated on July 29, 2015. It should be noted that some of the templates listed above have been sourced from recent agreements which have been reviewed and approved by outside counsel. It should also be noted that the templates listed above may require further review by outside counsel prior to implementation by TFHD staff due to the individualized nature of each agreement, and to ensure that the provisions of each agreement have been updated to reflect recent changes in law.

PURPOSE:

This policy provides Tahoe Forest Hospital District's Chief Executive Officer ("CEO") a framework for professional services contracting to ensure the professional service provider meets the needs of Tahoe Forest Hospital District ("TFHD" or "District") and the communities that it serves.

POLICY:

Written professional service agreements will be prepared for all health professionals who qualify as independent contractors and provide diagnostic or therapeutic services to TFHD's patients or provide certain medico-administrative duties within a hospital department or service.

The following health professionals are covered by this policy:

- Anesthesiologists
- Medical Directors
- Medical Staff officers
- Physicians providing services in the District's Multi-Specialty Clinics, Cancer Center or other professional practice settings operated by TFHD (collectively, "TFHD Practice Settings").
- Physicians serving in medical-administrative roles or on District committees
- Nuclear Medicine specialists
- Emergency Services physicians
- Occupational therapists
- Pathologists
- Physical therapists
- Radiologists
- Speech pathologists
- Emergency and urgent care providers
- Mid-level practitioners not employed by the District
- Hospitalists
- Other contracted health or medical service providers

PROCEDURES:

1. All professional service agreements will be developed between the CEO, or the CEO's designee, and the health professional.
   1.1. Health professionals are not permitted to provide professional services until an agreement has been approved by the District prior to the agreement effective date. Signatures will be obtained prior to the agreement effective date or in accordance with current Stark Law. Agreements containing amendments to the terms and conditions of the agreement must also be executed prior to the effective date and prior to the provision of professional services under the amended agreement.
   1.2. New and renewal agreements shall utilize the template agreement for the type of service required from the contracting professional (See Exhibit A, attached, for a list of available model agreements.)
   1.3. All agreements shall be reviewed by the Compliance Department. Agreements not utilizing the template agreement shall also be reviewed by legal counsel.
      1.3.1. Agreements committing $400,000.00 or more in any twelve-month period:
         1.3.1.1. Once agreement is reached between the CEO and health professional, CEO will present the provider-signed professional services agreement to the Board of Directors with the Contract Routing Form (or equivalent data summary report) with principal terms and conditions for their consideration. Principal terms and conditions include, but are not limited to, justification, term, compensation, scope of duties, total cost of contract, and other pertinent information, as applicable.

1.3.1.2. Upon review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions or direct a designated Board committee to review and make a recommendation to the Board of Directors.

1.3.1.3. Board approval of a professional services agreement constitutes direction to CEO to execute the professional service agreement.

1.3.2. Agreements committing less than $400,000 in any twelve-month period may be authorized by the CEO without Board approval when funds have been appropriated in the District's operating budget for the fiscal year.

1.4. Professional service agreements due for renewal may be held over for up to twelve months with no change in terms at the discretion of the CEO and in accordance with the Stark Law and applicable regulations. Note: Stark Law regulations currently permit unlimited holdover of physician professional service agreements when the contract stays within the Fair Market Value.

2. Urgent Services: At the discretion of the CEO, a professional service agreement required for urgent services may be executed if a quorum for a Special Meeting of the Board of Directors cannot be assembled. Compensation under Professional Service Agreements (PSA) With Physicians Only

2.1. New and renewal agreement will specify the financial arrangements related to the provision of physician professional services.

2.1.1. In no case shall compensation to physicians take into account the volume or value of anticipated or actual referrals physicians make to TFHD. TFHD shall endeavor to maintain a flexible approach with physicians within a specialty and among various specialties or TFHD Practice Setting, irrespective of referrals to TFHD generated by an individual physician or the type of specialty or the TFHD Practice Setting.

2.1.2. Management shall strive to create a model that is aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.

2.1.2.1. Pay within constraints of fair market value

2.1.2.2. Maintain internal equity within and between specialties

2.1.2.3. Provide sufficient compensation to recruit and retain physicians

2.1.2.4. Encourage quality and productivity

2.1.3. Be clear and understandable to all parties

The methodologies in this section 2 may be utilized to determine compensation with physicians.

2.2. Hourly rates. Hourly rates are the preferred compensation method for administrative duties such as medical directorships, preceptor, medical staff leadership positions, or committee attendance, and may also be used when clinical and administrative duties are combined. Hourly rates or "per shift" rates with hours of coverage and response time specified are the preferred compensation method for on-call and hospitalist coverage.

2.2.1. Physicians shall be required to document and attest to the date, hours worked or shifts covered.

2.2.2. In addition, a description of work completed or meetings attended will be provided for all administrative duties.

2.3. Rate per unit of production. The Work Relative Value Unit (WRVU) is the preferred measure of physician productivity and should be used as the unit of production whenever feasible. Payment at a set rate per WRVU is the preferred compensation method for physicians providing professional medical services under a professional service agreement in a TFHD Practice Setting, and may also be utilized for other physicians when mutually agreed upon by the parties.

2.3.1. The preferred source for establishing the rate per WRVU shall be a three-year average of the national median ratio of compensation to WRVUs published in the MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches that yield fair market value compensation may be substituted based upon the circumstances of the negotiation.

2.3.2. An alternate measure of productivity such as visits may be used as deemed necessary

by management.

2.4. Base compensation plus bonus. Payment of a fixed base compensation plus bonus is another acceptable compensation method for physicians who are providing professional medical services, half time or more, under a PSA in a TFHD Practice Setting. This methodology may be utilized for newly recruited physicians during the start-up phase (generally a year), for physicians in specialties where community demand is insufficient to support a full-time practice, or in other situations in which such method is needed for physician retention.

2.4.1. Base compensation shall be established based on an agreed upon percentage of the median compensation from one or more published compensation surveys.

2.4.1.1. Base compensation is defined as compensation prior to inclusion of compensation related to benefits/benefits allowance, excess ED On-call services, or administrative medical services.

2.4.1.2. FTE status shall be based on agreed number of days of work and/or hours of clinical availability, which may vary by specialty but which shall be consistent within each specialty.

2.4.1.3. The preferred source for establishing base compensation shall be the three-year average of the national median compensation published in the MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches to yield fair market value compensation may be substituted based on the circumstances of the negotiation.

2.4.1.4. The percentage of median may be established based on the physician's FTE status, historic productivity, years of experience, special expertise, or the difficulty of recruiting a particular specialty to the area.

2.4.2. A production-based bonus may be offered in addition to base compensation to encourage physician productivity.

2.4.2.1. Production shall be measured in WRVUs whenever possible.

2.4.2.2. A production target shall be established, and the production-based bonus shall be paid, only for production in excess of the established target.

2.4.2.3. A rate per unit of production shall be established as described above.

2.4.2.4. The preferred method for establishing the production target shall be dividing the rate per unit of production into the base compensation, provided however that the physician's cost of benefits and malpractice insurance may be considered in the calculation.

2.5. Malpractice insurance and benefits. The costs of malpractice insurance and benefits that are borne by the physicians shall be considered based on such reasonable methodology as may be developed by management, which may include but is not limited to:

2.5.1. Providing a fixed benefit allowance based on the estimated costs of malpractice insurance, health insurance, retirement benefits, employer-paid payroll taxes, and other benefits that are customarily paid by organizations with the ability to employ physicians.

2.5.2. Increasing the rate per WRVU or other unit of production on a percentage basis to account for such malpractice and benefit costs.

2.5.3. Reducing the WRVU target by an amount that would enable physicians to earn all or a portion of those costs by reaching a production level that is commensurate with their compensation.

2.6. Quality Incentive. Physician contracts may include a quality incentive, provided:

2.6.1. Quality incentives, if any, are measurable and linked to factors that are within the physician's control.

2.6.2. The total projected compensation, including incentives, does not exceed fair market value.

2.7. Payment per service. Payment at a specified rate per service is a permitted method for limited scope agreements in which the physician is providing clearly delineated clinical services. Examples include EKG interpretations, audiology reviews, and other services that are billed on a global basis by the hospital.

2.8. Specialty call activation fee. In specialties where a regular on-call panel is either infeasible due to

the number of physicians on the medical staff within that specialty or the low incidence of emergency need for that specialty, a specialty activation fee may be offered in the event that physician is called in to respond to an emergency.

2.9. Fair Market Value. In all cases, physician's total compensation must be within fair market value and must be determined to be commercially reasonable.

2.9.1. Fair market value for any individual contract shall generally be defined as an amount equal to or less than the 75th percentile of fair market value compensation, considering the physician's FTE status and production levels.

2.9.2. However management shall endeavor to design a compensation model that maintains the average physician's compensation between the 40th and 60th percentiles, based on the MGMA Physician Compensation and Production Surveys.

3. Multiple Agreements

3.1. Nothing in this policy shall prohibit TFHD from entering into multiple agreements with health professionals, provided the designated hours and types of service are clearly segregated.

3.1.1. Physicians whose professional duties under a PSA are during regular Monday through Friday daytime hours may have a separate agreement for on-call coverage during evenings, weekends, and scheduled days off and/or for administrative duties performed during lunch or after regular clinic hours.

3.1.2. Physicians working in a TFHD Practice Setting who provide hospitalist, on-call, or administrative services during normal scheduled clinic time shall receive WRVU credit in lieu of cash payment.

3.1.3. A physician may perform administrative duties while on call, as long as clinical duties are not needed. If a physician is needed for clinical duties, they may not bill administrative time when performing clinical duties.

3.1.4. Fair market valuations shall take into account the existence of multiple agreements with one contracting physician.

4. Physician Qualifications

4.1. Professional service agreements with physicians shall require:

4.1.1. A valid and unrestricted license to practice medicine in the state issued by the applicable state Medical Board;

4.1.2. Physician must achieve Board certification when eligible and/or maintain Board certification.

4.1.3. The physician is not suspended or excluded from participating in any federal health program;

4.1.4. All appropriate certifications, registrations and approvals from the Federal Drug Enforcement Administration and any other applicable federal or state agency necessary to prescribe and dispense drugs under applicable federal and state laws and regulations, in each case without restriction;

4.1.5. Prompt disclosure of the commencement, resolution or pendency of any action, proceeding, investigation or disciplinary proceeding against or involving physician, including, without limitation, any medical staff investigation or disciplinary action;

4.1.6. Prompt written notice of any threat, claim, or legal proceeding against TFHD that physician becomes aware of, and cooperation with TFHD in the defense of any such threat, claim, or proceeding and in enforcing the rights (including rights of contribution or indemnity) that TFHD may have against other parties or through its insurance policies;

4.1.7. No discrimination against a patient based on race, color, creed, religion, national origin, gender, sexual orientation, disability (including, without limitation, the condition(s) for which the patient seeks professional services from physician), marital status, age, ability to pay or payment source, or any other unlawful basis.

4.2. Physician Qualifications In Coordination With Medical Staff Bylaws:

4.2.1. Professional service agreements with physicians shall require their membership on

the respective hospital's Medical Staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

4.2.2. Termination of the agreement will cause the physician to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the physician would lose Medical Staff membership and privileges; he/she would simply lose the right to gain access to the service or department which is the subject of the exclusive agreement.

4.3. Contract Termination Clause

4.3.1. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon prior written notice.

4.3.2. The following language will be utilized:

4.3.2.1. "For cause" termination of a physician contract at any time during the term;

4.3.2.2. "No cause" termination during the initial or subsequent term. In the event a "no cause" termination occurs during the first year of the agreement, the parties may not enter into a new agreement for substantially the same services until after the expiration of the initial one-year term of the agreement.

4.3.2.3. The time-frame for prior written notice may range from 60-180 days. Further, termination of the agreement does not afford the physician the right to request a medical staff hearing or any other review under the Medical Staff By-Laws or rules and regulations, based on termination of the agreement.

5. Provisions For Non-Physician Health Professional Service Agreements

5.1. In all cases, the contract will specify the financial arrangements related to the provision of professional services. It is desirable that remuneration be based upon a set professional fee schedule rather than a percentage of gross or net patient charges. However, it is recognized that a wide variety of other mechanisms may be utilized and such other mechanisms are left to the discretion of the CEO and Board of Directors.

5.2. Compensation for health professional service agreements shall not exceed fair market value of the services.

5.3. Professional Fee Schedule

5.3.1. When reimbursement is based upon professional fee schedules, the fee schedule will be made a part of the agreement with the health professional. When provided for by agreement, professional fee schedule revisions will be considered once annually in a time-frame that coincides with the District's operating budget.

5.3.2. Requests for revisions should be submitted to the CEO by April of each year for implementation by July. The request should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees requested. The CEO determines whether the proposed changes are acceptable.

5.4. Health Professional Qualifications in Coordination with Medical Staff By-Laws:

5.4.1. Professional service agreements may require certain health professionals to be members of the District's allied health professional staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

5.4.2. Should a health services agreement be cancelled involving an allied health professional, termination of the agreement will cause the health professional to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the health professional would lose allied health professional appointment or related privileges.

5.5. Contract Termination Clause

5.5.1. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon written notice.

5.5.2. The timeframe for prior written notice may range from 60-180 days. When the health professional is required to be an allied health professional, termination of the agreement will not afford the allied health professional the right to request a due process hearing under any Medical

Staff bylaw, rule, or regulation for allied health professionals, based on termination of the agreement.

5.5.3. In all cases, professional service agreements will provide for termination "for cause" at any time during the contract term.

6. Physician and Health Professional Service Agreement Contract and Service Review
   6.1. At a minimum of every five years, the CEO or CEO's designee will conduct a service review of the contract service provided by the physician, physician group and/or other professional service.

7. General Contract Inclusion Terms: Physician and Health Professional Service Agreements
   7.1. Professional Service Duties and Responsibilities: Each agreement will include a detailed and specific delineation of the duties and responsibilities to be performed by the health professional as well as the District. For example, extensive detail will be provided regarding:
      7.1.1. Diagnostic and therapeutic services to be provided
      7.1.2. Medico-administrative services to be provided
      7.1.3. Coverage obligations to be assumed
      7.1.4. The rights and obligations of the District and the health professional with regard to providing space, equipment, supplies, personnel and technicians.
   7.2. Standards of Practice: Each agreement shall specify that the health professional will provide the service in accordance with the Hospital Bylaws; Medical Staff Bylaws, Rules and Regulations, and if applicable, standards established by the Executive Committee of the Medical Staff;
   7.3. Medicare and Medicaid Enrollment: Each agreement shall specify that the health professional is duly enrolled in the federal Medicare program and the applicable State Medicaid program (unless excepted by the District) and eligible to seek reimbursement under such programs for covered services rendered by the provider to beneficiaries of such programs. Every agreement must contain a provision in which the health professional agrees to notify TFHD in the event participation terminates.
   7.4. Quality Assessment: Professional service agreements shall require the health professional to participate in the Health System Quality Improvement Program to ensure that the quality, safety and appropriateness of healthcare services are monitored and evaluated and that appropriate actions based on findings are taken to promote quality patient care. Furthermore, each agreement shall specify a process designed to assure that all individuals who provide patient care services under service agreements, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services. Whenever possible, information from customer satisfaction surveys shall be incorporated into the Quality Improvement Program for the service. Agreements which provide for Directorship responsibilities over a department or service shall require the health professional "Director" to be responsible for implementing a monitoring and evaluation process designed to improve patient care outcomes and which is integrated with the Health System Quality Improvement Program.
   7.5. Assignability: It is desirable that all professional service agreements be non-assignable unless important to the successful negotiation of a contract where higher priority objectives may be achieved. Where assignability becomes necessary, assignability shall be allowed only with the condition that prior written consent of the District be obtained.
   7.6. Contract Term: Professional service agreements shall specify an effective date that is later than all requirements, including credentialing, being met. In considering the term of the agreement, the termination date of related agreements should be considered by the CEO so as to minimize the likelihood of multiple agreements coming due on the same date or year. The length of the term shall be negotiable. Professional service contracts will typically range from one to four years in duration.
   7.7. Professional Liability: In all cases, the health professional will be responsible for providing adequate professional liability insurance coverage at the health professional's expense. Limits of coverage for physicians will be a minimum of $1,000,000 per occurrence, $3,000,000 aggregate. For non-physicians, the minimum limits of coverage may vary depending on the standard established for that health profession in consultation with the District's risk manager. The agreement shall also specify

that the contracting health professional will, in turn, either require or arrange for professional liability insurance coverage for all sub-contracting health professionals. Furthermore, the professional liability insurance policy must be obtained from a professional liability insurer which is authorized to transact the business of insurance in the State of California (or Nevada in the case of professional services provided at the District's Nevada-based facilities). Also, the professional services agreement must require that the selected insurer will be responsible for notifying the District of any cancellation or reduction in coverage within thirty days of such action.

7.8. Regulatory Compliance: The agreement should include provisions in which both the District and the health professional commit to full compliance with all federal, state, and local laws. The contracting party should agree to keep confidential any financial, operating, proprietary, or business information relating to the District and to keep confidential, and to take the usual precautions to prevent the unauthorized use and disclosure of any and all Protected Health Information. The agreement should include provisions for amendment to the agreement in furtherance of maintaining compliance in the event of the adoption of subsequent legislation and/or regulations.

7.9. Recitals: Exclusive professional service agreements should include a carefully developed description of the rationales for exclusivity in a particular clinical service or department. Furthermore, if the agreement does assign exclusive responsibility for a particular service, it should state so expressly not leaving this to inference or interpretation.

7.10. Professional Relationships: The agreement should specify that the health professional is an independent contractor and is not an employee of the District.

7.11. Government Audit: The agreement should include the standard provision recognizing that the agreement and certain other materials will be subject to audit and inspection by certain federal authorities with regard to payments made for Medicare services.

7.12. Standard Contractual Language: The agreement should include certain standard provisions to the effect that the provisions of the contract are severable and, therefore, the ruling that any one of them is void does not invalidate the entire agreement, and that the waiver of breach of one provision does not constitute a continuing waiver, and that the written agreement constitutes the entire contract between the parties.

7.13. Managed Care: The physician or health professional agrees to participate as a preferred provider with all of the managed healthcare plans (PPOs and HMOs) that the District has agreements with including agreements with insurance companies, health maintenance organizations and direct contracting with self-funded employers. Any deviation of this policy must be approved by the CEO and the Board of Directors.

EXHIBIT A

No.	Contract Title	Last Date Modified
1	Call_Coverage_Agreement_Template_Individual_2015 **(version dated 8/11/14 does not have Master List provision)**	**3/30/2015**
2	Call_Coverage_Agreement_Template_Medical_Group_2015	4/16/2015
3	Confidentiality_Nondisclosure_Agreement_2015	3/25/2015
4	EKG_Letter_Agreement_Template_2014	10/29/2014
5	Non-Physician_Consultant_Agreement_Template_2014	9/25/2014
6	Hospitalist_Services_Agreement_Template_2014 **(Template has Master List provision Paragraph 2.4)**	**8/13/2014**
7	Interim_Physician_Designee_Contract_2014 **Version dated 02/23/2015 for Dr. Standteiner does not have Master List provision; add after 12. Governing Law)**	10/30/2014
8	Medical_Director_Agreement_Individual_2014 **(Dr. Tirdel's Med Dir of ICU & RT version on 2/23/15 has paragraph 11.3)**	**8/13/2014**
9	Medical_Director_Agreement_Medical_Group_2015	6/26/2015
10	MSC_PSA_Template_2014 **(Template has Master List provision Paragraph 2.5)**	8/13/2014
11	Retention_Agreement_Template_2015	4/23/2015
12	Recruitment_Agreement_Template_Co-obligors_2015 **(No Master List provision; add to VII Miscellaneous)**	**2/20/2015**
13	Recruitment_Agreement_Template_Physician-obligor_2015	**2/20/2015**

(No Master List provision; add to VII Miscellaneous)

14	Rural_Prime_Site_Preceptor_Template_2015	4/30/2015
15	TF2020_Agreement_for_Medical_Advisor_Services_2015	4/3/2015

This list was last updated on July 29, 2015. It should be noted that some of the templates listed above have been sourced from recent agreements which have been reviewed and approved by outside counsel. It should also be noted that the templates listed above may require further review by outside counsel prior to implementation by TFHD staff due to the individualized nature of each agreement, and to ensure that the provisions of each agreement have been updated to reflect recent changes in law.

Tahoe Forest Health System Master Planning

KAP
KELLY ARCHITECTURE & PLANNING
June 2017

Tahoe Forest Health System

Master Plan Goals

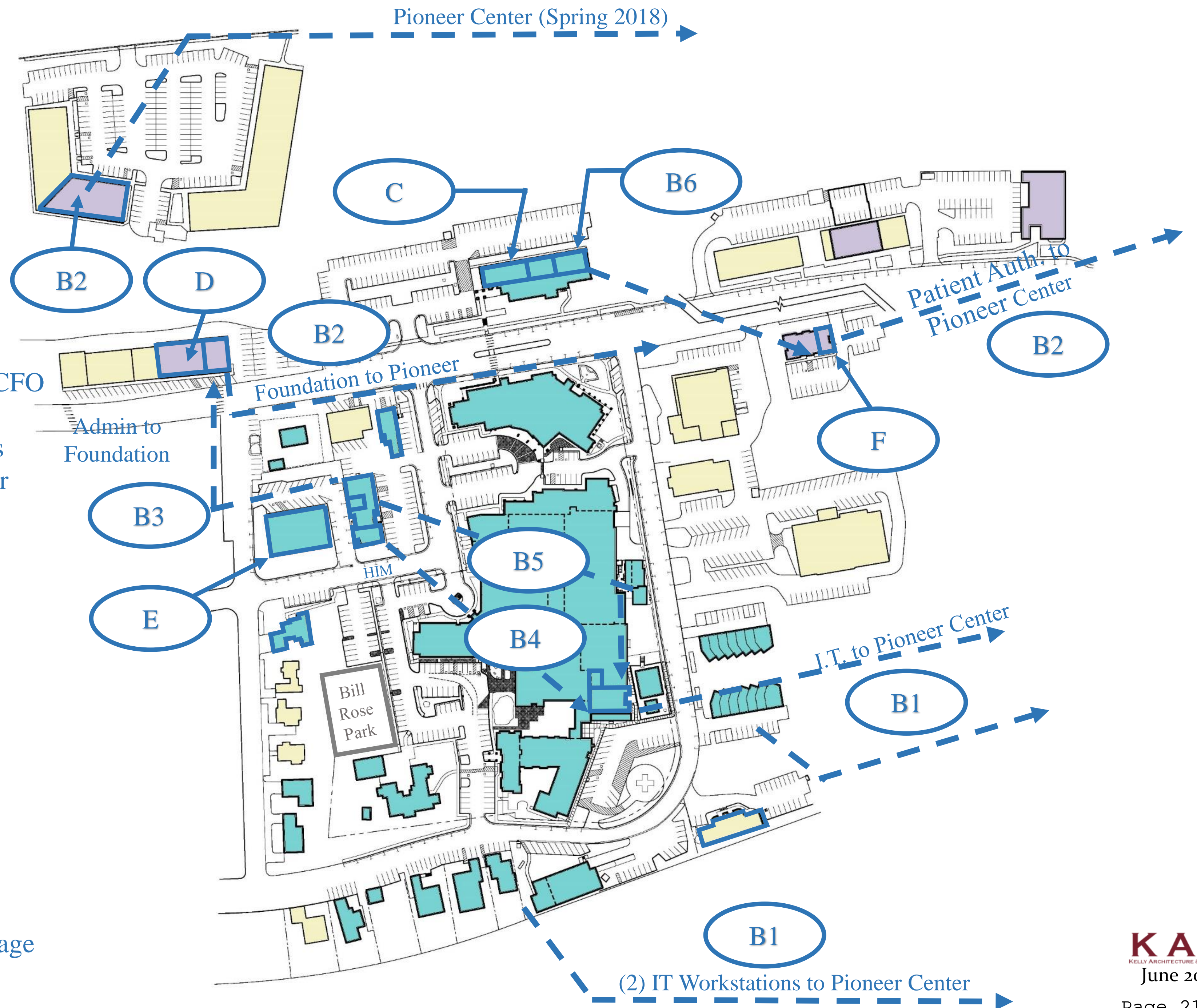
1. Develop Space for Maximum Service Line Capabilities
   - A. Build RHC Eligible Space to Maximize Reimbursement
   - B. Design Flexible Space for MultiSpecialty Usage (OSHPD 3)
     - Renovate 2nd and 3rd Floor of MOB and 2nd Floor of the Cancer Center
   - C. Consolidate Administration and Ancillary Services
     - Renovate Upper Level 1966 Building
2. Develop Strategy for Employee and Travelers Workforce Housing
3. Develop Short and Long Term Parking Plan
4. Develop Long Range Plan to Increase Ortho and Physical Therapy Capacity
5. Develop Long Range Plan to Consolidate All Departments to Hospital Campus

KAP
Kelly Architecture & Planning
June 2017

TAHOE FOREST HEALTH SYSTEM

Pre-Phase Projects

- A Execute 5 Year Lease to Pioneer Center- Completed
- B Relocate Ancillary Support
  - B1 IT and EPIC Training, CIO and CFO to Pioneer Center- In Progress
  - B2 Foundation, Marketing, Business Office, Finance to Pioneer Center Early 2018- In Progress
  - B3 Administration to Foundation
  - B4 HIM to 1st Floor 1950 Building
  - B5 MNT to 1st Floor 1966 Building
  - B6 Care Coordination, Patient Navigation, Prime (Suite 240) to Levon Building or Other Space
- C Relocate Dr. Condon (Suite 310) to Suite 240
- D Renovate IM / Cardiology Space
- E Renovate Ortho Building
- F Lease Additional Levon Space
- G Consolidate Thrift Store / Airport Storage
- H Develop Temporary Parking Solution

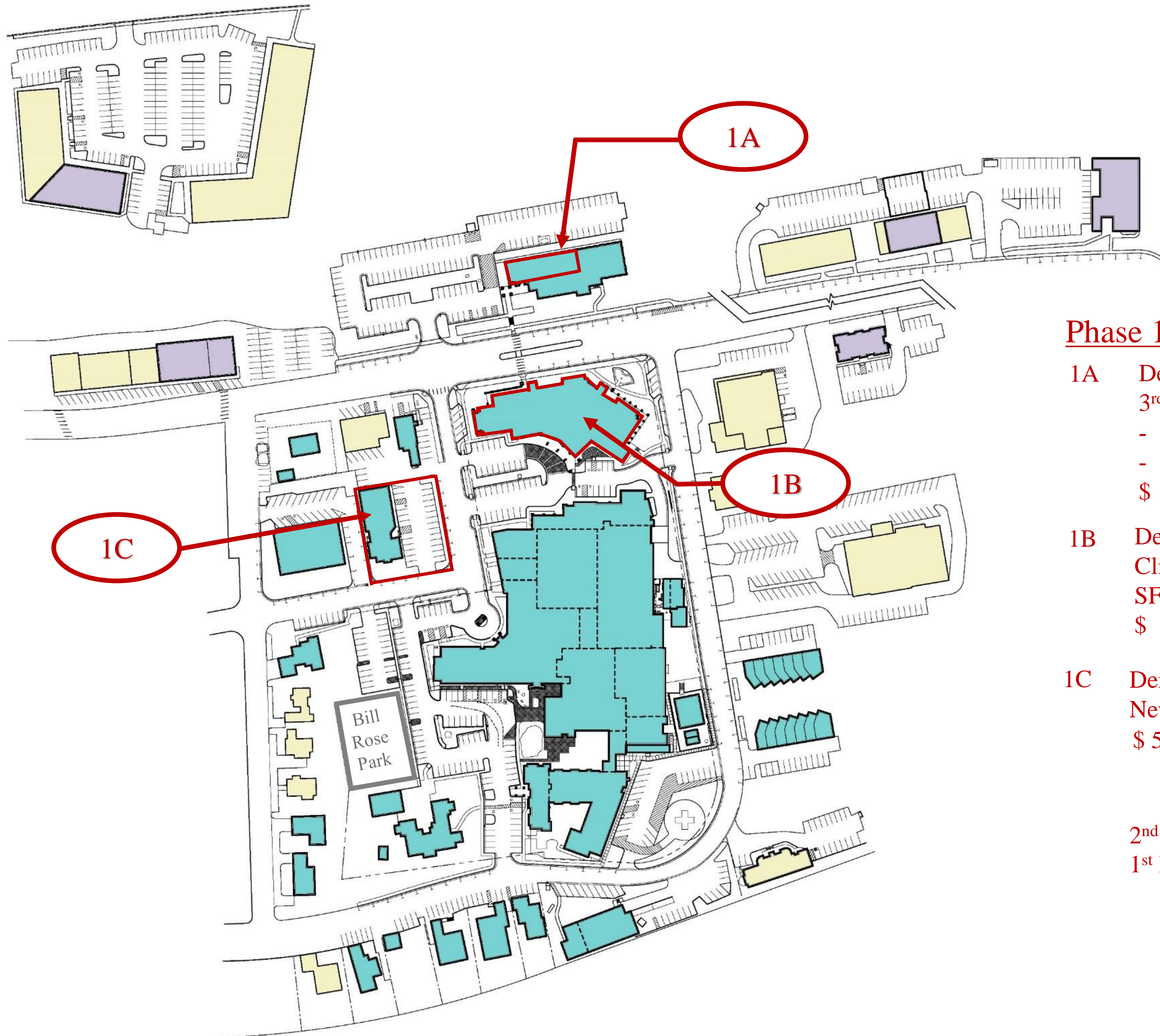


KAP
KELLY ARCHITECTURE & PLANNING
June 2017

Pre-Phase: Cost

A	5 Year Lease as Pioneer Center	$TBD
B.1	IT/Epic Training- Pioneer Center Phase 1	$60K
B.2	Found/Marketing/Business/Fin- Pioneer Center Phase 2	$90K
B.3	Admin to Foundation	$TBD
B.4	HIM to 1st Floor 1955 Building	$TBD
B.5	MNT to 1st Floor 1966 Building	$TBD
B.6	Care Coordination / Wellness to Levon	$TBD
C	Relocate Dr. Condon to Suite 240	$TBD
D	Renovate I/M Cardiology	$TBD
E	Renovate Ortho Building	$250k
F	Lease Additional Space	$TBD
G	Consolidate Thrift Store/Airport Storage	$TBD
H	Temporary Parking Solution	$TBD

TAHOE FOREST HEALTH SYSTEM



Phase 1: Construct OSHPD 3 Clinics

1A Design and Construct Pediatric Clinic on 3rd Floor MOB
- Phase 1 (4,339 SF)
- Phase 2 (6,048 SF)

$ 3.5M

1B Design and Construct Multi-Specialty Clinic on 2nd Floor Cancer Center (9,770 SF)

$ 4.9M

1C Demolish Admin Building and Construct New Parking to Support 2nd Floor Clinic

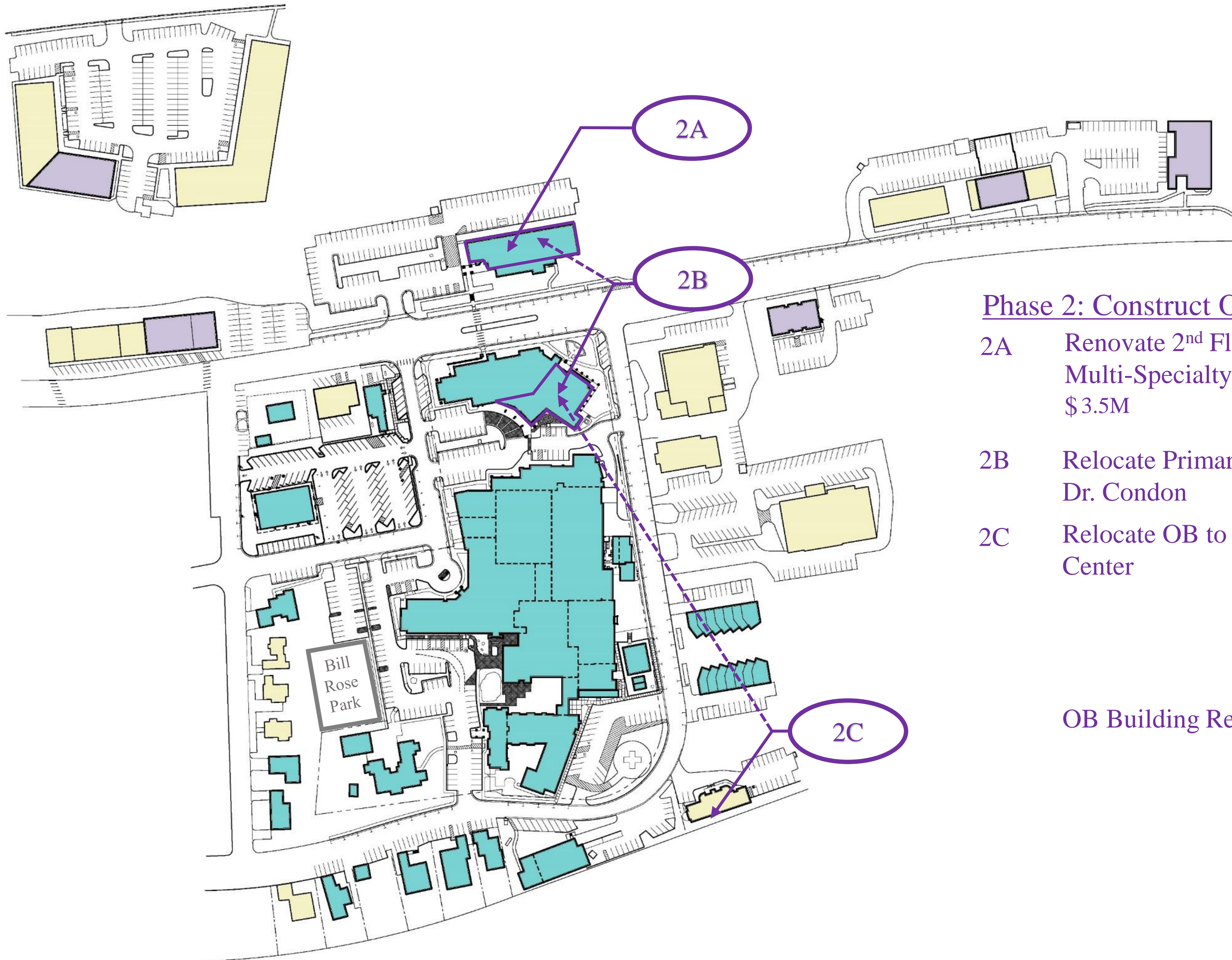
$ 500k / $12 SF

2nd Floor MOB Ready For Renovations

1st Floor Ped Clinic Ready for Reuse

KAP
KELLY ARCHITECTURE & PLANNING
June 2017

TAHOE FOREST HEALTH SYSTEM



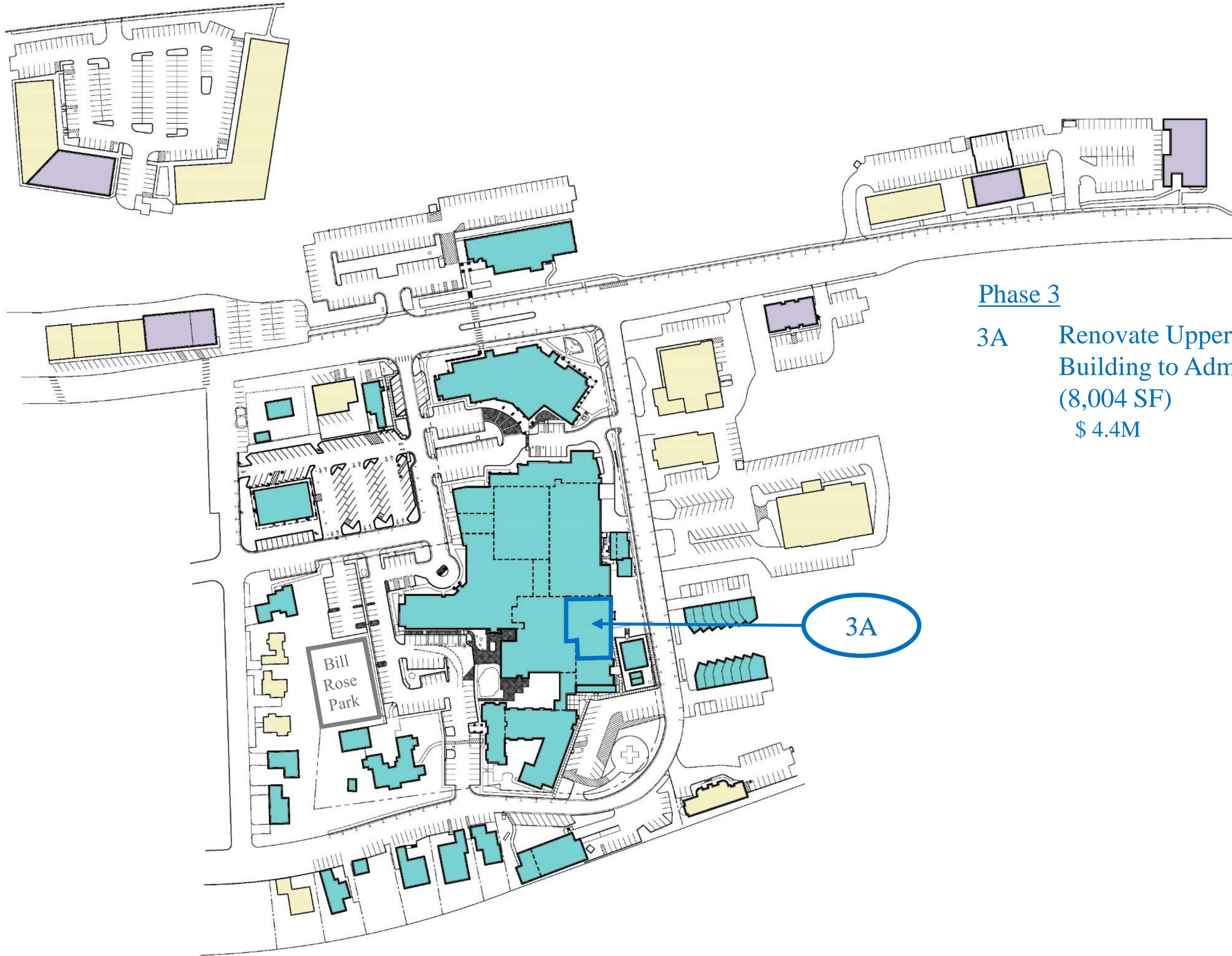
Phase 2: Construct OSHPD 3 Clinic

2A	Renovate 2nd Floor MOB to Multi-Specialty Clinics (5,950 SF) $ 3.5M
2B	Relocate Primary Care, Occ Health, Dr. Condon
2C	Relocate OB to 2nd Floor Cancer Center

OB Building Ready for Other Use

KAP
Kelly Architecture & Planning
June 2017

TAHOE FOREST HEALTH SYSTEM

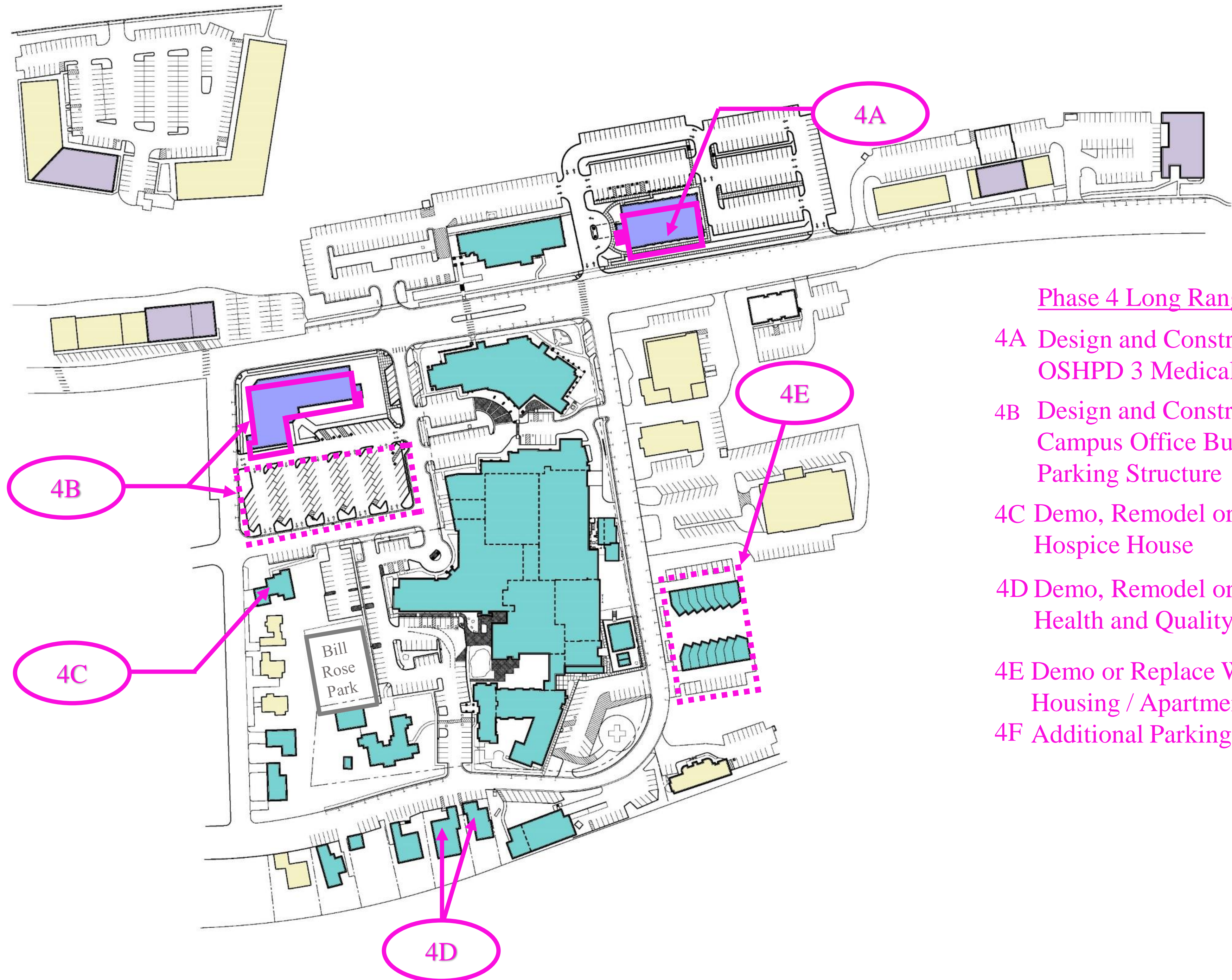


Phase 3

3A Renovate Upper Level 1966 Building to Administrative Support (8,004 SF)
$ 4.4M

KAP
KELLY ARCHITECTURE & PLANNING
June 2017

TAHOE FOREST HEALTH SYSTEM



Phase 4 Long Range Plan

4A Design and Construct New OSHPD 3 Medical Office Building

4B Design and Construct New On-Campus Office Building and Parking Structure

4C Demo, Remodel or Replace Hospice House

4D Demo, Remodel or Replace Home Health and Quality Bldgs.

4E Demo or Replace Workforce Housing / Apartments

4F Additional Parking at IVCH

KAP
KELLY ARCHITECTURE & PLANNING
June 2017

Discussion

A. Mental Health
B. Dental
C. Sleep Center OP Lab / Draw / Imaging
D. Parking
E. Adjoining Properties
F. Apartment Upgrades
G. Reuse of Women's Center
H. Reuse of 1st Floor Ped Clinic

Legend: Budgeting/Predesign | Design | Plan Review | Bidding | Construction

Timeline: 2016-2017 (Q3: J F M; Q4: A M J) | 2017-2018 (Q1: J A S; Q2: O N D; Q3: J F M; Q4: A M J) | 2018-2019 (Q1: J A S; Q2: O N D; Q3: J F M; Q4: A M J)

#	ahoe Forest Hospital Projects	KAP #	
	South Building Occupancy	-	
	Epic Training	-	Training
1	1966 Building Vacated Spaces	201.15.1C	
2	1966 Building Sprinkler Bracing	201.15.1C.1	
3	Nurse Call/PA Replacement	201.17	
4	Fire Alarm Replacement	201.21	
5	Interim OB Replacement	201.23	
6	2nd Floor Cancer Center TI's	201.24	
7	3rd Floor MOB Peds Clinic TI's	201.25	
8	1966 Admin Tenant Improvements	201.26	
9	Mammo Replacement	201.27	
10	Project Closeouts	201.29	
11	1978 Building Reroof	201.32	
12	Post Measure 'C'	201.33.2	
13	TF Master Plan	201.36.3	
14	Pharmacy Clean Room	201.41	
15	First Floor Corridor Doors	201.44	
16	MNT Offices	201.45	
17	MPOE HVAC	201.46	
18	1955 Building HIM	201.47	
19	Pioneers Trail P1	201.49.1	
20	Pioneers Trail P2	201.49.2	
21	Ortho Building Improvements	201.50	
22	IM/Cardiology Improvements	201.51	
23	Foundations/Admin Relocation	201.52	TBD
24	2nd Floor MOB TI's	201.53	
25	Admin Parking/Site Improvements	201.56	
26	Physical Therapy Improvements	201.57	
27	ECC Building Reroof	201.58	
28	Children's Center Generator	201.59	
	ncline Village Projects		
29	IVCH ED Registration	201.02.5	
30	IVCH HVAC Upgrades	201.14	
31	IVCH Lab	201.18	
32	IVCH Site Improvements	201.61	

GOVERNANCE COMMITTEE AGENDA

Wednesday, June 14, 2017 at 3:00 p.m.
Eskridge Conference Room - Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**
   Randy Hill, Chair; Chuck Zipkin, M.D.

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT – AUDIENCE**
   This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. **CLOSED SESSION**

5.1. Approval of Closed Session Minutes: 02/15/2017

5.2. Hearing (Health & Safety Code § 32155)
Subject Matter: Compliance Report – Closed Session
Number of items: One (1)

6. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**

6.1. Policy Review

6.1.1. ABD-21 Physician and Professional Service Agreements Policy .... ATTACHMENT
Governance Committee will review revisions to ABD-21 Physician and Professional Service Agreements Policy.

6.2. Board Committee Structure Discussion.. ATTACHMENT
Governance Committee will discuss the current and proposed board committee structure.

7. **APPROVAL OF MINUTES OF:** 09/14/2016, 02/15/2017

8. **REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

9. **NEXT MEETING DATE**
   The Governance Committee will discuss its next meeting date.

10. **ADJOURN**

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

FINANCE COMMITTEE AGENDA

Tuesday, June 20, 2017 at 2:00 p.m.
Foundation Conference Room - Tahoe Forest Health System Foundation
10976 Donner Pass Rd, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**
   Dale Chamblin, Chair; Alyce Wong, Board Member

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT – AUDIENCE**
   This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. **APPROVAL OF MINUTES OF: 4/25/2017** .... ATTACHMENT

6. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**

6.1. Financial Reports

6.1.1. Financial Report – May 2017 .... ATTACHMENT
6.1.2. Quarterly Review – Multi-Specialty Clinics .... ATTACHMENT
6.1.3. Quarterly Review – Tahoe Forest Health System Foundation .... ATTACHMENT
6.1.4. Quarterly Review – Truckee Surgery Center, Inc. – January – March 2017 ..... ATTACHMENT

6.2. FY18 Budget Update .... ATTACHMENT
The Finance Committee will receive an update on the fiscal year 2018 budget, including preliminary volumes.

7. **REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

8. **AGENDA INPUT FOR NEXT FINANCE COMMITTEE MEETING** .... ATTACHMENT

9. **NEXT MEETING DATE** .... ATTACHMENT

10. **ADJOURN**

. *Denotes material (or a portion thereof) may be distributed later.

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