AGENDA ITEM NO.
C-6

COUNTY OF HUMBOLDT

For the meeting of: October 8, 2013

Date: September 23, 2013

To: Board of Supervisors

From: Phillip R. Crandall, Director AC for PC
Department of Health and Human Services – Mental Health Branch

Subject: Approval of the Bylaws of Sempervirens

RECOMMENDATION(S):

That the Board of Supervisors, acting as the Governing Body of Sempervirens Psychiatric Health Facility and with the recommendation of the Department of Health and Human Services Mental Health Branch Medical Staff Executive Committee approve the revised Bylaws of Sempervirens.

SOURCE OF FUNDING:

Mental Health Fund

DISCUSSION:

The Governing Body of Sempervirens Acute Psychiatric Health Facility (PHF) is responsible for the final approval of any revisions to the Bylaws of Sempervirens. Attached is a copy of the revised Bylaws, as they were recommended by the Medical Staff Executive Committee at their meeting of September 23, 2013.

Title 22, Section 77081 of the California Code of Regulations governing psychiatric health facilities requires that the governing body establish written bylaws. They were last approved by the Board of Supervisors in 1996. The changes were necessitated to conform to current Federal and State rules and

Prepared by Karen Smith, Medical Staff Coordinator CAO Approval

REVIEW:
Auditor ____ County Counsel KR Personnel ____ Risk Manager ____ Other ____

TYPE OF ITEM:
X Consent
____ Departmental
____ Public Hearing
____ Other ____

PREVIOUS ACTION/REFERRAL:

Board Order No. ____

Meeting of: ____

BOARD OF SUPERVISORS, COUNTY OF HUMBOLDT
Upon motion of Supervisor Bass Seconded by Supervisor Bohn

Ayes Bass, Lovelace, Sundberg, Bohn, Fennell
Nays
Abstain
Absent

and carried by those members present, the Board hereby approves the recommended action contained in this Board report.

Dated: October 8, 2013
By: Kathy Hayes
Kathy Hayes, Clerk of the Board

regulations.

FINANCIAL IMPACT:

There is no impact to the County General Fund. The approval of the Bylaws supports the Board's Strategic Framework by protecting vulnerable populations.

OTHER AGENCY INVOLVEMENT:

None

ALTERNATIVES TO STAFF RECOMMENDATIONS:

Board Discretion.

ATTACHMENTS:

Revised Bylaws of Sempervirens

HUMBOLDT COUNTY MENTAL HEALTH

BYLAWS OF SEMPERVIRENS

APPROVED:

GOVERNING BODY (BOS) ____ (DATE)____

HUMBOLDT COUNTY MENTAL HEALTH
BYLAWS OF SEMPERVIRENS

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PREAMBLE

WHEREAS, Humboldt County Department of Heath and Human Services – Mental Health Branch operates the county psychiatric health facility known as Sempervirens, licensed under the laws of the state of California; and

WHEREAS, the mental health services at Sempervirens are provided under medical supervision; and

WHEREAS, it is recognized that the quality of medical care in the facility is vested with the Medical Staff and, as such, must accept and discharge this responsibility, subject to the authority of the Governing Body, and that the cooperative efforts of the Medical Staff, the Medical Director, and the Governing Body are necessary to fulfill the facility's obligations to its patients;

THEREFORE, the physicians practicing in this facility hereby organize themselves into a Medical Staff, in conformity with these bylaws which have been approved by the Governing Body.

ARTICLE I: NAME

The name of this organization shall be the Humboldt County Mental Health Sempervirens Medical Staff.

ARTICLE II: PURPOSES AND ORGANIZATIONS

The purposes of organization are:

1. The Medical Staff of Sempervirens Psychiatric Health Facility is dedicated to the accomplishment of the facility's mission, stated as:

   As a component of Humboldt County Mental Health Services' continuum of care, the mission of the Sempervirens Psychiatric Health Facility is to provide, within the limit of resources, psychiatric assessment or evaluation or crisis intervention oriented treatment to eligible persons, who, as a result of mental illness, are gravely disabled or a danger to themselves or others. Subject to the authority of the Governing Body, integrated with other community resources, the facility's clinical services will be monitored for effectiveness and efficiency and will be provided in an environment of safety and dignity for patients and staff.

2. To insure that all patients admitted to, or treated in any component of the psychiatric health facility will receive appropriate medical care.

3. To serve as the primary means for accounting to the Governing Body that an adequate level of professional performance is maintained by all practitioners authorized to practice in the facility, through the appropriate delineation of the clinical privileges that each practitioner may exercise in the facility and through an ongoing review and evaluation of each practitioner's performance in the facility.

4. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.

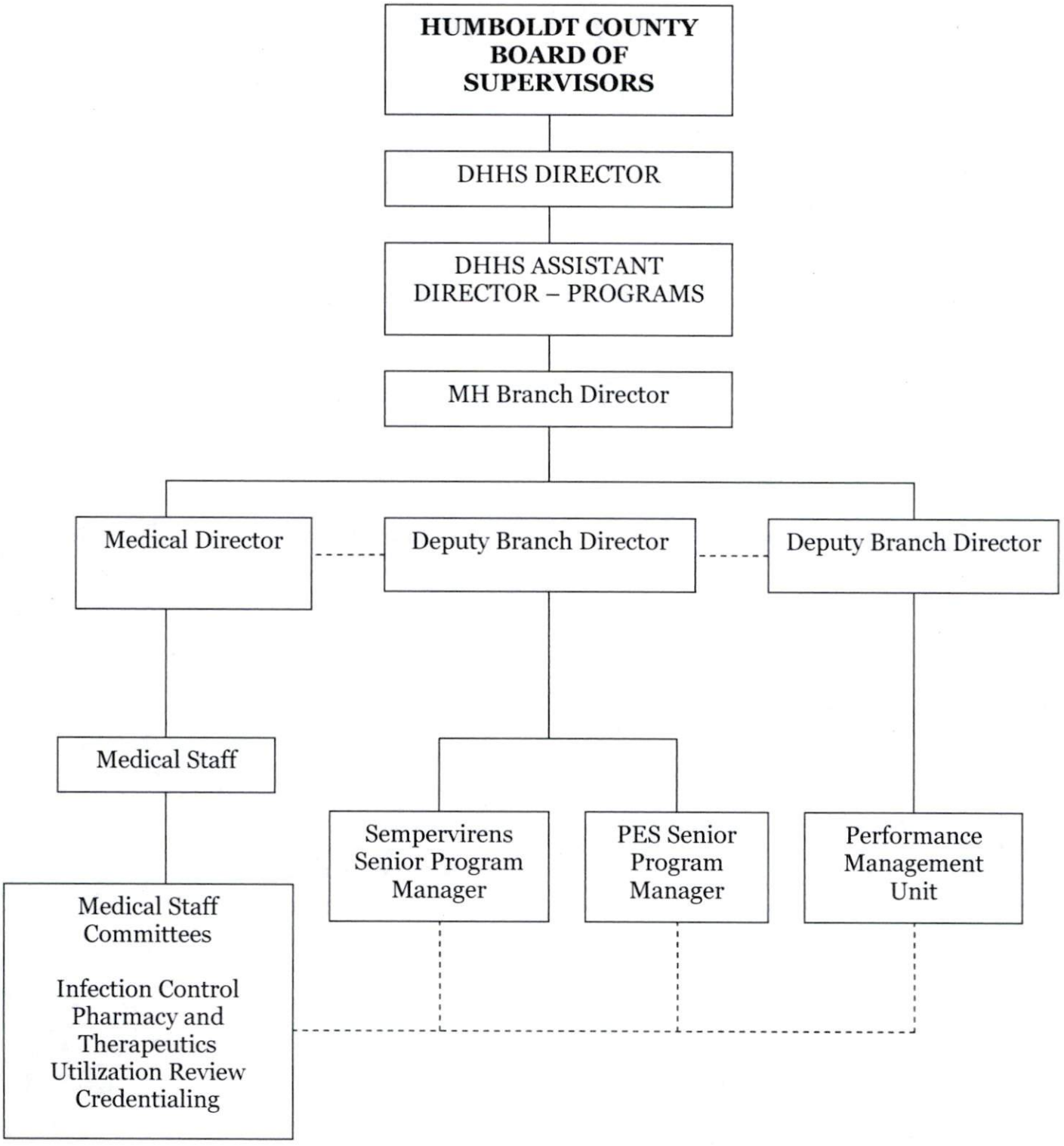
5. To initiate and maintain rules and regulations for the proper functioning of the Medical Staff.

6. To provide a means whereby issues and quality assurance activities concerning the Medical Staff and the facility may be discussed by the Medical Staff with the Governing Body and the President of the Medical Staff, through the Joint Conference Committee.

7. To provide for the proper utilization and supervision of allied health professionals.

8. The organization of the Medical Staff shall be in the organizational chart.

ORGANIZATIONAL CHART



ARTICLE III: MEDICAL STAFF MEMBERSHIP

Section 1 – Nature of Medical Staff Membership

Membership on the Medical Staff of Humboldt County Mental Health Sempervirens is not a right but a privilege which may be extended only to professionally competent physicians who continuously meet the qualifications, standards, and requirements set forth by these bylaws. Only practitioners who are duly appointed shall have clinical privileges and the right to admit patients to the facility. The Humboldt County Mental Health Facility, Sempervirens, operates with a closed Medical Staff. Only those with current employment or those on contract are entitled to membership. Membership automatically ceases with termination of employment and expiration or cancellation of contract.

Section 2 – Qualifications for Membership

a. General Qualifications
California Licensed Practitioners, including physicians (M.D. or D.O.), physician assistants, nurse practitioners or clinical psychologists, who meet the following requirements for medical staff membership shall be considered for appointment to the Humboldt County Mental Health Sempervirens Medical Staff.

All applicants must:

(i) Document their (1) current California licensure, (2) adequate experience, education and training, (3) current professional competence in the care of patients in the facility as demonstrated by submission of at least two (2) letters of reference, (4) good judgment, (5) current adequate physical and mental health status (subject to any necessary reasonable accommodation), so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive a high quality of psychiatric and/or medical care, (6) current query from the National Practitioners Databank, and (7) report from the Medical Board of California.

(ii) Demonstrate their intention (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care or jeopardize the ability of the treatment team to provide quality patient care, (3) to keep confidential, as required by law, all information or records received or developed in the physician-patient relationship, and (4) to willingly participate in and properly discharge those responsibilities as required by the Medical Staff, including peer review;

(iii) Get clearance from the Department of Justice on criminal record check pursuant to Section 5405 of Welfare and Institutions Code.

(iv) Physicians: An applicant for physician membership in the Medical Staff must hold an M.D. or D.O. degree and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. Applicants must provide evidence of completion of a formal training in their intended field of practice.

(v) Non-physician healthcare professionals must hold an appropriate degree in the respective discipline and a valid and unsuspended certificate to practice issued by the licensing body for the profession (Medical Board of California, California Board of Registered Nursing, California Board of Psychology). A Nurse Practitioner must have a collaborative agreement with at least one MD or DO on staff.

b. Non-Discrimination: No aspect of Medical Staff membership or particular privileges shall be denied on the basis of race, religion or religious creed, color, age (over 40), sex (including gender identity and expression, pregnancy, childbirth and related medical conditions), sexual orientation (including heterosexuality, homosexuality and bisexuality), national origin, ancestry, marital status, medical condition (including cancer and genetic characteristics), mental or physical disability (including HIV status and AIDS), military service, or any other classification protected by federal, state, or local laws or ordinances. Physical or mental impairments that do not pose a threat to the quality of patient care shall not be cause of denial of clinical privileges. Presence or absence of board certification will not be used as the sole criteria to grant medical staff membership or privileges. This does not require the granting of privileges to unqualified persons.

Section 3 – Basic Responsibilities of Staff Membership

Each member of the Medical Staff shall:

a. Provide patients with appropriate recognized professional level quality of care.

b. Abide by the Medical Staff Bylaws, Rules and Regulations and by all other lawful standards, policies and rules of the facility, established by the Medical Staff as approved by the Governing Body.

c. Discharge such staff, committee, and facility functions for which responsible by appointment, election, or otherwise.

d. Prepare and complete in a timely matter the medical and other required records for which responsible.

e. Abide by professional ethical principles of the facility which include but are not limited to:

    1) Refrain from fee splitting or other inducements relating to patient referral.

    2) Provide for continuous care of patients in the facility.

    3) Refrain from delegating the responsibility for diagnosis or care of admitted patients to a practitioner who is not known to be qualified to undertake this responsibility.

    4) Seek consultations required by the Medical Staff Bylaws, Rules and Regulations and whenever warranted by a patient's condition.

f. Report unprofessional or substandard activities or conduct of fellow staff members.

g. Accept responsibility for emergency care of any patient at the facility.

h. Active Medical Staff and Temporary Staff comprising of licensed physicians and nurse practitioners must undergo all training requirements as mandated by the facility, including the seclusion and restraint training.

Section 4 – Conditions and Duration of Appointment

a. Initial appointments and reappointments to the Medical Staff shall be made a duty of the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these bylaws; provided that, in the event of unwarranted

delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

b. Initial appointments and reappointments shall be made for a maximum period of two (2) years. At the end of the second year of each appointment or reappointment, the Governing Body shall consider each member of the Medical Staff for additional periods not to exceed two (2) years, after undergoing a reappraisal process.

c. A reappraisal is conducted every twenty-four (24) months to evaluate the suitability of continuing the medical staff membership or privileges of each individual practitioner, to determine if that individual practitioner's membership or privileges should be continued, discontinued, or revised.

d. The reappraisal evaluates each individual practitioner's qualifications and demonstrated competencies to perform each task or activity for which he/she has been granted privileges. The evaluation addresses current work practice, special training, quality of specific work, patient outcomes, education, maintenance of continuing education, adherence to medical staff rules, certifications, licensure, and compliance with current licensure requirements.

e. Only practitioners employed by the County or operating under a properly executed contract with the County may be appointed to the Medical Staff. Termination of employment or contracts will automatically terminate membership in the Medical Staff of this facility.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 1 – The Medical Staff

The Medical Staff shall include Active Staff, Consulting Staff, Allied Health Professional Staff, and Temporary (Locum and Extra-Help) Staff.

Section 2 – Active Medical Staff

The Active Medical Staff shall consist of physicians and nurse practitioners who are employed or contracted to care for patients in the facility, in accordance with the privileges granted by the Medical Staff credentialing and privileging process. The Active Medical Staff assumes all the functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, emergency service care and consultation assignments within the scope of their privileges. Members of the Active Medical Staff shall be eligible to vote, to hold office, and to serve on the Medical Staff committees, and shall be required to attend Medical Staff meetings at least quarterly. As for their qualifications, they should meet the qualifications set forth in Article III, Section 2.

Section 3 – Consulting Medical Staff

The Consulting Medical Staff consists of physicians, nurse practitioners or physician's assistants who provide, on a consulting basis, direct clinical services. They may not attend Medical Staff meetings and may not vote on any Medical Staff matter. Licensed practitioners completing

patient medical history and physical examinations and practitioners providing tele-medicine would be considered under this category. As for their qualifications, they should meet the qualifications set forth in Article III, Section 2. Medical Staff will periodically appraise the privileges of the Consulting Medical Staff.

Section 4 – Allied Health Professional Staff

a. The Allied Health Professional Staff shall consist of licensed physician's assistants and clinical psychologists, as defined by appropriate rules and regulations of the State of California. They shall not be eligible for appointment to the active Medical Staff. Their credentials shall be processed in the same manner as is required for Medical Staff members. They may serve by appointment, but not vote on Medical Staff Committees. They shall not be appointed as committee chair. They shall not hold office in the Medical Staff organization. They shall not have the rights of practitioners as delineated in Articles VII and VIII of these bylaws except as described in Article VII, Section 4. No provision of these bylaws, rules and regulations shall be interpreted to provide privileges in excess of the statutory limitations of the State of California.

Section 5 –Temporary Staff

The Temporary Staff consists of Locum Tenens and Extra-Help licensed physicians who will be appointed by the same process as the active staff and should meet the qualifications set forth in Article III, Section 2. The Temporary Staff will be periodically appraised by the Medical staff for continuation of their Medical Staff membership and privileges, which would be for a maximum of two (2) years at a time. Privileges for Temporary Staff will be delineated by the Medical Director.

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1 – Application for Appointment

a. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on an application form. The application shall require detailed information concerning the applicant's personal qualifications, training and experience, shall include the names of at least two (2) persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character, and shall include information as to whether the applicant's membership status has ever been revoked, suspended, reduced or not renewed at any other facility or institution, and as to whether membership in local, state or national medical societies, or licenses to practice in any jurisdiction, has ever been suspended or terminated.

b. The applicant shall submit adequate information for proper evaluation of competence, character, ethics, and other qualifications. Applicants claiming board certification shall provide appropriate documentation demonstrating such qualifications. Applicants claiming board eligibility shall provide documentation of formal residency training leading to such eligibility. Appointment to Medical Staff membership and granting of privileges will not be solely dependent upon board certification or membership in a particular body or society.

c. By applying for appointment to the Medical Staff, the applicant thereby signifies a willingness to appear for interview in regard to the application. By signing a Release of Information, the applicant authorizes the facility to consult with members of Medical

Staffs of other facilities with which the applicant has been associated and with others who may have information bearing on competence, character and ethical qualifications. The applicant shall sign any Releases of Information or releases from liability required by the responding Credentials Committee, Executive Committee or designee. The applicant consents to the facility's inspection of all records and documents including relevant peer review information or records that may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested as well as moral and ethical qualifications for staff membership releases from any liability to the fullest extent permitted by law, all representatives from the facility, its Medical Staff, employees, and the County of Humboldt for their acts concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

d. The application form shall include a statement that the applicant has received and read the bylaws, rules and regulations of the Medical Staff and agrees to be bound by the terms thereof if the application is approved.

Section 2 – Appointment Process

a. After receiving completed applications for new staff membership, the President of the Medical Staff and/or the Local Mental Health Director may grant interim privileges to applicants to the Medical Staff while their applications are being considered by committees and the Governing Body. Clinical privileges shall be delineated and monitored in accordance of Article VI of these bylaws. Interim privileges granted in this manner may be suspended at any time pending final action by facility committees and the Governing Body. Suspensions shall be imposed in all cases when any committee action is unfavorable to a practitioner, pending final reviews by other committees and the Governing Body. Interim privileges granted to applicants for Medical Staff membership shall be in accordance with Article VI, Section 2.

b. Within ninety (90) days after receipt of the completed application for membership, the Credentials Committee shall make a written report of investigation to the Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standards of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the committee, whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by him or her. Together with this report, the Credentials Committee shall transmit to the Executive Committee, the completed application and a recommendation that the practitioner either be appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration.

c. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Executive Committee shall determine whether to recommend to the Governing Body that the practitioner be appointed to the Medical Staff, be rejected for Medical Staff membership, or that application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

d. When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within forty-five (45) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership.

e. When the recommendation of the Executive Committee is favorable to the practitioner, the President of the Medical Staff shall promptly forward it, together with all supporting documentation, through the Local Mental Health Director to the Governing Body for final approval.

f. When the recommendation of the Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the President of the Medical Staff shall promptly notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the practitioner has exercised, or has been deemed to have waived, the right to a hearing, as provided in Article VIII of these bylaws.

g. If, after the Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Executive Committee's reconsideration and recommendation is favorable to the practitioner, it shall be processed in accordance with paragraph "e" above. If such recommendation continues to be adverse, the President of the Medical Staff shall promptly so notify the practitioner, by certified mail, return receipt requested. The President of the Medical Staff shall also forward such recommendation to the Local Mental Health Director, but the Local Mental Health Director shall not take any action thereon until after the practitioner has exercised, or has been deemed to have waived the right to, an appellate review as provided in Article VIII of these bylaws.

h. After receipt of a favorable recommendation, the Governing Body shall act on the matter as soon as possible. If the Governing Body's decision is not favorable, the President of the Medical Staff shall promptly notify the practitioner of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised, or has been deemed to have waived, rights under Article VIII of these bylaws and until there has been compliance with paragraph "j" below. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

i. As soon as it can be possibly scheduled at its next regular meeting, after all of the practitioner's rights under Article VIII have been exhausted or waived, the Governing Body or its duly authorized representative shall act on the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter back to the Local Mental Health Director for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, if any, the Governing Body shall make a decision either to appoint the practitioner to the staff or reject him or her for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the practitioner may exercise.

j. Whenever the Governing Body's decision will be contrary to the recommendation of the Executive Committee, the Governing Body shall submit the decision to the Joint Conference Committee for review and recommendation and shall consider such recommendation before making its decision final.

k. When the Governing Body's decision is final, it shall send notice of such decision to the Medical Staff Coordinator, through the Local Mental Health Director, and the Medical Staff Director or Medical Staff President will notify the practitioner of the decision.

l. Following favorable decisions by the Governing Body, applicants shall be notified of their staff appointments by the President of the Medical Staff.

m. For appointment to Medical Staff for tele-medicine services, the governing body will approve the use of the credentialing and privileging processes laid out under the Code of Federal Regulations, Title 42 section 482.22 and California Business and Professions Code section 2290.5.

Section 3 – Reappointment Process

a. At least every two (2) years, each member of the Medical Staff shall be provided with a reappointment application. Within thirty (30) days the completed form shall be returned to the President of the Medical Staff. Failure, without good cause, to return the completed application shall be deemed a voluntary resignation effective at the expiration of the staff member's current appointment. The application shall include information necessary to update the Credentials file: an application requesting medical staff membership and privileges; evidence of current licensure and report obtained from the State of California's Department of Consumer Affairs Medical Board on-line license lookup system (or Osteopathic Medical Board or Board of Registered Nursing license search, as applicable); evidence of training and maintenance of continued medical evaluation (CME) credits as delineated by the Medical Board of California; evidence of quality of work performed as demonstrated by peer review and report from PMU-QI (Performance Management Unit – Quality Improvement); current query from the National Practitioners Databank; at least two (2) supporting references for competence; a statement relating to the current physical and mental health status of the member; a statement of agreement to abide by the Medical Staff Bylaws, Rules and Regulations; a current certification of CPR training; a review of the member's current privileges; and a statement concerning the member's desire to retain or change the current privileges.

b. By applying for reappointment and accepting reappointment, the staff member signifies continuing acknowledgment and acceptance of the provisions of Article V, Section 1. d, and Article III, Section 3.

c. The reappointment application shall be processed in substantially the same manner and subject to the same conditions as for new applications (Article V, Section 2). Application will be subject to approval of the Governing Body.

d. Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients, ethics, conduct, attendance at Medical Staff meetings, and participation in staff affairs, compliance with the facility bylaws and the Medical Staff Bylaws, Rules and Regulations, cooperation with facility personnel, relations with other practitioners, and general attitude toward patients, the facility and the public.

e. When a Medical Staff member requests not to be reappointed or fails to return the completed application for reappointment as provided in Article V, Section 3. a, such requests or failures shall be presented to the Credentials Committee for review and recommendation. The Credentials Committee shall forward its recommendation to the Executive Committee whose recommendation shall be passed to the Governing Body by the Local Mental Health Director for its decision which shall be final.

f. A staff member may request a modification of the staff category, or voluntarily relinquish any privileges at any time. Such requests shall be in writing and shall be processed in the same manner as are applications for reappointment. Requests for additional privileges may be made at any time, but must be requested separately, in writing, together with evidence demonstrating the candidate's qualifications for any additional privileges requested. Such a request must be appraised by the Medical Staff and approved by the Governing Body. Notice of any changes in privileges must be given to the facility where the Staff practices.

ARTICLE VI: CLINICAL PRIVILEGES

Section 1 – Clinical Privileges Restricted

a. Every practitioner practicing at this facility by virtue of Medical Staff membership or otherwise shall, in connection with any such practice, be entitled only those clinical privileges specifically granted.

b. Every initial application for staff membership must contain a request for the specific clinical privileges desired by the applicant. The applicant shall have the burden of establishing qualifications and competency in the clinical privileges requested. The evaluations of privilege requests shall be done by the Credentials Committee, and the Executive Committee, and shall be based on the applicant's education and training, experience, demonstrated competence in other facilities, references, reputation, and other relevant material. Final approval of privileges for staff members shall be the duty of the Governing Body.

c. A staff member may request a modification of the staff category, or voluntarily relinquish any privileges at any time. Such requests shall be in writing and shall be processed in the same manner as are applications for reappointment. Requests for additional privileges may be made at any time, but must be requested separately, in writing, together with evidence demonstrating the candidate's qualifications for any additional privileges requested. Such a request must be appraised by the Medical Staff and approved by the Governing Body. Notice of any changes in privileges must be given to the facility where the staff practices.

d. Periodic redetermination of clinical privileges shall be made every two (2) years at the same time that staff members are considered for reappointment to the Medical Staff. Determinations to maintain or to curtail current privileges shall be based upon the direct observation of care and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care. Decisions detrimental to staff members shall be subject to the hearing and appellate review procedures of these bylaws.

e. Privileges granted to Allied Health Professionals shall be based on their training, experience, and judgment as well as demonstrated competence in accordance with the Medical Staff rules and regulations.

Section 2 – Locum Tenens Privileges

a. Locum Tenens privileges may be granted to properly licensed practitioners who are applicants for staff membership and awaiting appointment.

b. The President of the Medical Staff and/or the Local Mental Health Director may grant approved Locum Tenens privileges. Practitioners with Locum Tenens privileges shall be monitored and evaluated by members of the Medical Staff. Locum Tenens staff will be reappraised periodically by the Medical Staff and every two (2) years will be reappointed under Article V, Section 3.

c. Practitioners granted Locum Tenens privileges may have their privileges summarily suspended or further restricted at any time by the Local Mental Health Director independently or upon the recommendations of the President of the Medical Staff or the Governing Body.

d. Practitioners granted such Locum Tenens privileges shall submit a signed acknowledgment that they have received and read a copy of these bylaws, rules and regulations, and that they agree to abide by the provisions therein.

ARTICLE VII: CORRECTIVE ACTION

Section 1 – Procedure

a. Any person may provide information to the Medical Staff about the conduct or activities of its members. A corrective action investigation may be initiated whenever reliable information indicates that a Medical Staff member may have engaged in, made, or exhibited statements, demeanor, or professional conduct that is reasonably likely to be (i) detrimental to patient safety or to the delivery of quality patient care services; (ii) disruptive to the operations of the facility thus compromising the ability of other members and hospital employees to deliver quality patient care; (iii) unethical; (iv) contrary to Medical Staff Bylaws, rules or regulations; (v) below applicable professional standards. A corrective action against such practitioner may be requested by any officer of the Medical Staff, by the chair of any standing committee of the Medical Staff, by the President of the Medical Staff, Local Mental Health Director, or by the Governing Body. All requests for corrective action shall be in writing, shall be made to the Credentials Committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request.

b. Within thirty (30) days after the Credentials Committee's receipt of the request for corrective action, the Credentials Committee shall make a report of its investigation to the Executive Committee. Prior to the making of such report, the practitioner shall be informed of the general nature of the charges against him or her, and shall be invited to discuss, explain or refute them before the Credentials Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws, with respect to hearings, shall apply thereto. A record of such interview shall be made by the Credentials Committee and included with its report to the Executive Committee.

c. Within thirty (30) days of the receipt of a report from the Credentials Committee, following its investigation of a request for corrective action involving reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall be used by the Executive Committee.

d. The action of the Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation, requirement for consultation, to recommend education, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend to the Local Mental Health Director that the practitioner's staff membership be suspended or revoked.

e. After the Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article VIII, if applicable, of these bylaws.

f. Any recommendation by the Executive Committee to the Mental Health Director for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff, shall entitle the affected practitioner to the procedural rights provided in Article VIII of these bylaws.

g. Any recommendation by the Executive Committee to the Governing Body for reduction, suspension or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff, shall entitle the affected practitioner to the procedural rights provided in Article VIII of these bylaws.

h. The chair of the Credentials Committee shall promptly notify the President of the Medical Staff and Local Mental Health Director, in writing, of all requests for corrective action received by the Credentials Committee and shall continue to keep the President of the Medical Staff and the Local Mental Health Director fully informed of all action taken in connection herewith.

i. In those instances in which the Credentials Committee's or Executive Committee's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the governing body shall have the authority to direct the Credentials Committee or Executive Committee to initiate an investigation or a disciplinary action, but only after consultation with these committees. No such action shall be taken in an unreasonable manner.

j. In the event the Credentials Committee or Executive Committee fail to take action in response to a direction from the governing body, the governing body shall have the authority to take action against a practitioner. Such action shall only be taken after written notice to the Credentials Committee or Executive Committee and shall entitle the affected practitioner with the procedural rights provided in Article VIII of these bylaws.

Section 2 – Summary Suspension or Restriction

a. The Medical Director, or Acting Medical Director, in consultation with the Local Mental Health Director shall have the authority, whenever action must be taken immediately in the best interest of patient care, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition.

b. When no person authorized by the Medical Staff Bylaws is available to summarily suspend or restrict clinical privileges under circumstances specified in subdivision (a), the Governing Body or its designee may immediately suspend a practitioner's clinical privileges if a failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any individual, provided the Governing Body of Sempervirens has, before the suspension, made reasonable attempts to contact the Executive Committee. A suspension by the Governing Body of Sempervirens which has not been ratified by the Executive Committee within two (2) working days, excluding weekends and holidays, after the suspension shall terminate automatically.

c. The Medical Staff member affected by the summary suspension or restriction will be notified within one working day of the imposition of the suspension or restriction. The initial written notice shall include a statement of facts demonstrating the suspension or restriction was necessary because failure to restrict or suspend the member's privileges summarily could reasonably result in danger to the health of a patient or the conduct of the Medical Staff member either is or could become unacceptably disruptive to the operations of the facility.

d. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Executive Committee hold a hearing on the matter, within such reasonable time period thereafter as the Executive Committee may be convened, in accordance with Article VIII of these bylaws. The request for a hearing is to be in writing to the Executive Committee through the Medical Director or Medical Staff President.

e. The Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Executive Committee does not recommend immediate termination of the summary suspension, the affected practitioner shall, also in accordance with Article VIII, be entitled to request an appellate review by the Governing Body, but the terms of the summary suspension, as sustained or as modified by the Executive Committee, shall remain in effect pending a final decision thereon by the Governing Body.

f. Immediately upon the imposition of a summary suspension, the chair of the Executive Committee or the Local Mental Health Director shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the facility at the time of such suspension.

Section 3 – Automatic Suspension

Notification from the appropriate agency of the revocation or suspension of a Medical Staff member's license, drug enforcement agency registration, or being placed on probation, shall automatically constitute sufficient grounds for the Executive Committee to recommend to the Local Mental Health Director the suspension or revocation of such member's Medical Staff membership, or to recommend the placement of such member on probation for the period, and to the same extent, imposed by the agency. There shall be no right of appeal or hearing from any actions taken by the Governing Body in such cases.

Section 4 – Corrective Action for Consulting Staff/Allied Health Professionals

Corrective action for Allied Health Professionals may be initiated by the Credentials Committee, the President of the Medical Staff, or supervising practitioners. Should such action result in a reduction or suspension of privileges, the allied health professional may request a hearing from the Executive Committee. Following such hearing, a recommendation shall be made to the Governing Body whose action shall be final.

Procedures for hearing and appellate review are set forth in Article VIII of these bylaws of Sempervirens.

ARTICLE VIII: HEARING AND APPELLATE REVIEW PROCEDURE

Section 1 – Right to Hearing and to Appellate Review

a. When any practitioner receives notice of a recommendation of the Executive Committee that, if ratified by decision of the Governing Body, will adversely affect appointment to, or status as a member of, the Medical Staff or exercise of clinical privileges, the practitioner shall be entitled to a hearing before an ad hoc committee of the Medical Staff so appointed to hear the issue. Such ad hoc committee shall make its recommendation to the Executive Committee of the Medical Staff. If the recommendation is adverse to the affected practitioner, an appellate review by the Governing Body may be requested. The decision of the Governing Body is final.

b. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in these bylaws to assure that the affected practitioner is accorded all rights to which entitled.

Section 2 – Request for Hearing

a. The President of the Medical Staff shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review by certified mail, return receipt requested. The practitioner may, by written notice to the Medical Director delivered through the Local Mental Health Director, by certified mail, return receipt requested, request a hearing.

b. The failure of a practitioner to request a hearing, to which entitled by these bylaws, within a period of fourteen (14) days following the date of written notice of an adverse recommendation or decision and in the manner herein provided shall be deemed a waiver of the right to such hearing and to any appellate review to which might otherwise have been entitled on the matter. The failure of a practitioner to request an appellate review, to which entitled by these bylaws, within the time and in the manner herein provided shall be deemed a waiver of the right to such appellate review on the matter.

Section 3 – Notice of Hearing

a. Within seven (7) days after receipt for hearing from a practitioner entitled to the same, the Executive Committee or the Governing Body, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the President of the Medical Staff, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall be not less than fourteen (14) days nor more than forty-five (45) days from the date of receipt of the request of hearing; provided, however, that a hearing for a practitioner who is under suspension, which is then in effect, shall be held as soon as arrangements therefore may reasonably be made, but not later than fifteen (15) days from the date of receipt of such practitioners request for hearing.

b. The notice of hearing shall state in concise language the acts or omissions which the practitioner is charged with, a list of specific or representative charts being questioned, and other reasons or subject matter that was considered in making the adverse recommendation or decision.

Section 4 – Composition of Hearing Committee

a. When a hearing specifically relates to an adverse recommendation of the Executive Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Medical Staff in consultation with the Executive committee, and one of the members so appointed shall be designated as chair. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed as a member of this hearing committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff.

b. When a hearing related to an adverse decision of the Governing Body that is contrary to the recommendation of the Executive Committee, the Governing Body shall appoint a hearing committee to conduct such hearing and shall designate one member of this committee to serve as chair. At least one representative from the Medical Staff shall be included on this committee.

Section 5 – Conduct of Hearing

a. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

b. An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc committee, and may be accomplished by the use of a court reporter, electronic recording unit, detailed transcription, or by taking adequate minutes.

c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails, without good cause, to appear and proceed at such a hearing shall be deemed to have waived rights and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect.

d. Postponement of hearings beyond the time set forth in these bylaws shall be made only with the approval of the ad hoc hearing committee. Grants of such postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

e. The affected practitioner shall be entitled to be accompanied by, and represented at the hearing by, a member of the Medical Staff in good standing or by a member of the local professional society.

f. Either a hearing officer, if one is appointed, or the chair of the committee or designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

g. The hearing need not be conducted strictly according to rules of law relating to examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become part of the hearing record.

h. The Executive committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of the adverse decision, and to examine witnesses. It shall be the obligation of such representatives to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting the challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis, or that such basis or any action based thereon is either arbitrary, unreasonable, or capricious.

i. The affected practitioner shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witnesses on any matter relevant to the issue of the hearing, to challenge any witnesses and to rebut any evidence. If the practitioner does not testify on his or her own behalf, the practitioner may be called and examined as if under cross-examination.

j. The hearings provided for in these bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct.

shall be given by certified mail, return receipt requested, and shall include a statement that attendance at the meeting, at which the alleged deviation is to be discussed, is mandatory.

Failure by a practitioner to attend any meeting when given notice that attendance was mandatory, unless excused by the Executive Committee upon showing of good cause, shall result in an automatic suspension of all, or such portion of, the practitioner's clinical privileges as the Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate showing that absence will be unavoidable, such presentation may be postponed by the President of the Medical Staff or by majority vote of the Executive Committee if the President is the practitioner involved, until not later than the next meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.

Section 5 – Morbidity and Mortality Conferences

At the request of the Local Mental Health Director or the President of the Medical Staff, a special meeting to evaluate special cases shall be held. The review shall be a function of the Continuous Quality Improvement Committee as part of that committee's peer review function.

ARTICLE XII: RULES AND REGULATIONS

The Medical Staff shall adopt each rule and regulation as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the facility. Such rules and regulations shall be a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice, by a two-thirds vote of those present of the active Medical Staff. Such changes shall become effective when approved by the Governing Body.

ARTICLE XIII: AMENDMENTS

These bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment shall be referred to a special committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds majority vote of the Active Medical Staff members present. Amendments so made shall be effective when approved by the Governing Body.

ARTICLE XIV: ADOPTION

These bylaws, together with the appended rules and regulations, shall be adopted at any regular or special meeting of the Active Medical Staff and shall replace any previous bylaws, rules and regulations. These bylaws, rules and regulations shall become effective when approved by the Governing Body of the facility.

ARTICLE XV: GENERAL PROVISIONS

The Medical Staff may retain and be represented by independent legal counsel at the expense of the Medical Staff.

ARTICLE XVI. AUTHORITY OF THE LOCAL MENTAL HEALTH DIRECTOR

Notwithstanding any other provision of these Bylaws, no appointment or reappointment to membership or granting of clinical privileges shall be effective unless and until approved by the Local Mental Health Director, or designee, and no suspension or termination (including denial of reappointment) of membership or all or part of the clinical privileges of any person shall be effective unless and until approved by the Local Mental Health Director. In cases of emergency the Local Mental Health Director shall have the authority to suspend an individual's Medical Staff membership and/or part of the clinical privileges of any person for a period not to exceed five (5) days pending investigation and action by the Local Mental Health Director.

Notwithstanding any other provision of these Bylaws, the Local Mental Health Director or a physician designee should the Local Mental Health Director not be a physician, shall, in the interest of patient care and at his or her sole discretion, have the authority to grant clinical privileges lesser than those requested as well as modify, suspend or terminate the membership and/or all or part of the clinical privileges of any person.

Notwithstanding any other provision of these Bylaws, except as otherwise provided in this Article XVI, the Local Mental Health Director shall not designate the authority to act for him or her on the matters covered.

ARTICLE XVII: CONFLICT WITH LAWS

In the event of a conflict between the provision of these Bylaws and any other County ordinance or state or federal law or regulation, the provision with the higher standard of care will prevail. In any case, no provision of these bylaws shall be construed as to supersede any Personnel Policy of the County of Humboldt.

HUMBOLDT COUNTY MENTAL HEALTH MEDICAL STAFF OF SEMPERVIRENS RULES AND REGULATIONS

1. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a licensed staff member and signed within 24 hours by the physician ordering the treatment or the next physician assuming care of the patient. Orders dictated over the telephone shall be signed by the licensed staff to whom it was dictated and shall be counter-signed within 24 hours and dated by the physician ordering the treatment or the next physician assuming care of the patient.

2. Only those symbols and abbreviations which have been approved by the Medical Staff and have an explanatory legend shall be used.

3. Patients may be admitted only on an order by physicians and nurse practitioners who have been duly appointed to the Medical Staff.

4. Each patient admitted to Sempervirens will have a medical history and physical examination completed and documented no more than thirty (30) days before or twenty-four (24) hours after admission. The medical history and physical examination must be completed and documented by a licensed physician or other qualified licensed nurse practitioner or physician assistant in accordance with State law and hospital policy. When the history and physical examination is conducted within thirty (30) days before admission, an update must be completed within twenty-four (24) hours of admission by a licensed practitioner who is credentialed and privileged by the hospital's Medical Staff to perform history and physical examination.

5. A Psychiatric Evaluation shall be completed within twenty-four (24) hours of admission, utilizing the approved Psychiatric Evaluation format.

6. The Master Interdisciplinary Treatment Plan shall be prepared within seventy-two (72) hours of admission to Sempervirens, and shall be signed and dated by the appropriate disciplines.

7. Psychiatric progress notes shall be written on each patient on a daily basis.

8. Only licensed physicians and nurse practitioners cleared to work on Sempervirens and having received the seclusion and restraint training will be ordering seclusion and restraint on patients on Sempervirens. Restraint and Seclusion procedures and documentation shall be conducted as defined in the current Restraint and Seclusion policy and procedure.

9. A member of the Active Medical Staff shall be available by telephone at all times for emergencies as defined in current policy and procedure.

10. Discharge Planning is initiated at the time of admission. The Medical Staff and Social Service staff shall be involved collaboratively.

11. All Active Medical Staff physicians and mid-level practitioners shall be required to have current CPR certification.

12. Each physician shall be responsible for ensuring that the on-call coverage assigned to them is provided.

13. Prior to transfer, the admission of all patients must be approved by a member of the Active Medical Staff after directly communicating with the transferring providers.

14. Organ and Tissue Donation shall be conducted in accordance with current policy and procedure.

15. The Medical Staff shall participate in the Quality Assurance monitoring of this facility.

16. For any transfers out of facility, the physician or nurse practitioner will communicate with the accepting provider and also see the patient one hour before the transfer.

17. The Active and Temporary Medical Staff will submit their Service Activity Logs (SALs) to Medical Records by 5:00 p.m. next business day. If using benefit time, it is the responsibility of the staff member to submit SALs for this time.

18. Completion of medical records and discharge summaries: The Medical Staff acknowledges the importance of timely completion of medical records and discharge summaries in providing quality patient care. The discharge summaries have to be dictated with fourteen (14) days of discharge and will be out of compliance if not done within thirty (30) days of discharge. Corrections on charts for patients discharged from Sempervirens will be out of compliance if not done within thirty (30) days of discharge.

19. The Medical Staff will identify those staff qualified to perform the Medical Screening Exam (MSE) by a list of those qualified to perform the MSE updated monthly by the DON (see Medical Screening Examination policy and procedure).

Accordingly, neither the affected practitioner, nor the Executive Committee or the Governing Body, shall be represented at any phase of the hearing procedure by an attorney at law unless the hearing committee, in its discretion, permits both sides to be represented by counsel. The foregoing shall not be deemed to deprive the practitioner, the Executive Committee, or the Governing Body, to the right to legal counsel in connection with preparation for the hearing or for a possible appeal. If a hearing officer is utilized, an attorney at law who is acceptable to both sides may be used.

k. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at any time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

l. Within fifteen (15) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Governing Body, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Governing Body.

Section 6 – Appeal to the Governing Body

a. Within fifteen (15) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the practitioner may, by written notice to the Governing Body delivered through the Local Mental Health Director, by certified mail, return receipt requested, request an appellate review by the Governing Body, held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement, provided for below, or may also request that oral argument be permitted as part of the appellate review.

b. If such appellate review is not requested within fifteen (15) days, the affected practitioner shall be deemed to have waived the right to same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately.

c. Within twenty (20) days after receipt of such notice of request for appellate review, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Local Mental Health Director, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than fourteen (14) days, nor more than sixty (60) days, from the date of the receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than forty-five (45) days from the date or receipt of such notice.

d. The appellate review shall be conducted by the Governing Body or by a duly appointed appellate review committee of the Governing Body of not less than two (2) members.

e. The affected practitioner shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him or her. The practitioner shall have ten (10) days to submit a written statement in his or her own behalf, in which those factual and procedural matters with which there is disagreement, and the reasons for such disagreement shall be specified. This written

statement also may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Body, through the Local Mental Health Director, by certified mail, return receipt requested, at least ten (10) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Executive Committee or by the chair of the hearing committee appointed by the Governing Body, and if submitted, the President of the Medical Staff shall provide a copy thereof to the practitioner at least ten (10) days prior to a hearing date of such appellate review by certified mail, return receipt requested.

f. The Governing Body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to paragraph "e" above for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him or her by any member of the appellate review body.

g. New or additional matters not raised during the original hearing or in the hearing committee report, not otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Governing Body or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matter shall be accepted.

h. If the appellate review is conducted by the Governing Body, it may affirm, modify, or reverse its prior decision or, at its discretion, refer the matter back to the Executive Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve specified disputed issues.

i. If the appellate review is conducted by a committee of the Governing Body, such committee shall, within fifteen (15) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Body affirm, modify, or reverse its prior decision, or refer the matter back to the Executive Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve disputed issues. Within thirty (30) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Body as above provided.

j. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived.

Section 7 – Final Decision by the Governing Body

a. Within fourteen (14) days after the conclusion of the appellate review, the Governing Body shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the Local Mental Health Director, to the affected practitioner, by certified mail, return receipt requested. If the decision is in accordance with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Executive Committee's last such recommendation, the Governing Body shall refer the matter to a Joint Conference

11. To take reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of, and participation in, Medical Staff corrective or review measures when warranted.

12. To report a summary of its activities at each general Medical Staff meeting.

13. To initiate and pursue corrective action when warranted in accordance with these bylaws, rules and regulations.

14. To ensure an effective quality assurance program.

15. To act on behalf of the Medical Staff between Medical Staff meetings.

c. Meetings: The Executive Committee shall meet at least quarterly.

Section 4 – Credentials Committee

a. Composition: The credentials Committee shall be composed of three Active Medical Staff members.

b. Duties:

1. To review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges.

2. To make a report to the Executive Committee on each applicant for Medical Staff membership or clinical privileges.

3. To periodically review all information available regarding the competence of staff members and, as a result of such reviews, to make recommendations for the granting of clinical privileges and reappointments.

4. To investigate any break of ethics that is reported to it, and to investigate any request for corrective action, and report its findings to the Executive Committee.

c. Meetings: The Credentials Committee shall meet at least quarterly.

Section 5 – Utilization Review Committee

a. Composition: Voting membership shall consist of at least one active member of the Medical Staff, and the Medical Director, at least one of whom is a psychiatrist; the Local Mental Health Director, Utilization Review Coordinator, Continuous Quality Improvement Coordinator, and the Medical Records Supervisor.

b. Duties:

1. The Utilization Review Committee shall conduct utilization review studies designed to evaluate the appropriateness of admissions to the facility, length of stay, discharge practices, use of medical and facility services and all related factors which may contribute to the effective utilization of facility and physician services. Specifically, it shall analyze how under-utilization and over-utilization of each of the facility's services affects the quality of patient care and obtain criteria relating to average or normal lengths of stay by specific disease categories, and shall evaluate systems of utilization review employing such criteria. It shall also work toward the assurance of proper continuity of care upon discharge through,

among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the facility. The committee shall communicate the results of its studies and other pertinent data to the entire Medical Staff and shall make recommendations for the optimal utilization of facility resources and facilities commensurate with quality of patient care and safety.

2. The Utilization Review Committee shall also formulate a written utilization review plan for the facility. Such plan, as approved by both the Medical Staff and Governing Body, must be in effect at all times and must include all of the following elements:

    - The organization and composition of the committee which will be responsible for the utilization review function.
    - Frequency of meetings.
    - The types of records to be kept.
    - The method to be used in selecting cases on a sample or other basis.
    - The definition of what constitutes the period of extended duration.
    - The relationship of the utilization review plan to the claims administration by a third party.
    - Arrangement for committee reports and their dissemination.
    - Responsibilities of the facility's administrative staff in support of utilization review.

c. Meetings: The Utilization Review Committee shall meet at least quarterly.

Section 6 – Pharmacy and Therapeutic Committee

a. Composition: Membership shall consist of at least two (2) representatives of the Medical Staff, consulting pharmacist, Director of Mental Health Nursing, and the Continuous Quality Improvement Coordinator.

b. Duties: This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the facility in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad policies regarding the evaluation, appraisal, selection procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the facility. It shall also:

    1. Serve as an advisory group to the facility Medical Staff and the pharmacist on matters pertaining to the choice of available drugs.

    2. Make recommendations concerning drugs to be stocked on the nursing unit.

    3. Develop and review periodically, a formulary or drug list for use in the facility.

    4. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

    5. Evaluate clinical data concerning new drugs/preparations requested for use in the facility.

    6. Establish standards concerning the use of, and control of, investigational drugs and research in the use of recognized drugs.

7. Conduct an ongoing antibiotic utilization review including specific record reviews referred to the committee by the Infection control Practitioner, and to take corrective actions as indicated.

8. Review all serious untoward drug reactions which have had a detrimental impact on patients.

9. A pharmacist shall review the drug regimen of 10% of patients (or minimum of 6) at least monthly and prepare a report to be submitted to the Pharmacy and Therapeutics Committee.

c. Meetings: The Pharmacy and Therapeutics Committee shall meet at least quarterly.

Section 7 – Infection Control Committee

a. Composition: Membership shall include one active member of the Medical Staff, the Medical Director, Infection Control Practitioner, Director of Mental Health Nursing, the Continuous Quality Improvement Coordinator, and the Local Mental Health Director or designee.

b. Duties:

1. To define, classify, and report nosocomial infections.

2. To evaluate, record, and report infection among patients and employees.

3. To develop, review, and enforce written policies and procedures defining specific indications for the isolation of patients.

4. To perform concurrent and retrospective patient care evaluation studies relating to infections, including specific case reviews.

5. To develop, and periodically revise, a facility-wide infection control manual.

6. To develop, revise, and conduct an employee health program.

7. To provide for the orientation of new employees to the facility procedure for infection control and personal hygiene.

8. To provide, document, and review in-service education relating to infection.

9. To periodically review cleaning procedures, agents, and schedules and approve any major changes.

10. To review and evaluate all aseptic and sanitation techniques used in the facility.

11. To conduct surveillance, preventive, and control procedures relating to the inanimate facility environment.

12. To provide and revise forms for the collection and collation of relevant data.

13. To provide for necessary laboratory support of microbiological and serological nature.

14. To coordinate with the Pharmacy and Therapeutics Committee regarding antibiotic utilization reviews.

1. To provide the Continuous Quality Improvement Committee and other elements of the Quality Assurance system with input into and from the professional staff that works on Sempervirens on a daily basis.

2. To insure that quality care is provided to Sempervirens patients.

3. To identify, assess and prioritize problem areas with potential for improvement.

4. To suggest solutions for problems to appropriate authorities and committees.

5. To monitor and evaluate the results of problem solving activities.

6. Minutes will be kept of each Inpatient Mental Health Services Committee meeting. A summary of the recommendations of this sub-committee will be forwarded to the Continuous Quality Improvement Committee.

c. Meetings: The Inpatient Mental Health Services Committee will meet a frequently as necessary.

Section 9 – Joint Conference Committee

a. Composition: The Joint Conference Committee shall be a standing committee composed of an equal number of members of the Governing Body and the Medical Staff. Composition will include two members of the Medical Staff and two members of the Governing Body. Members from the Medical Staff shall include, at least, the President and another member of the Medical Staff. The Local Mental Health Director and Medical Director shall be ex-officio members without voting privileges. Any member of the committee shall have authority to place matters on the agenda for consideration. The chair shall be elected from the voting members.

b. Duties:

1. The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of facility policy and practice, especially those pertaining to efficient and effective patient care, and shall provide liaison with the Governing Body and the Medical Staff.

2. The Joint Conference Committee may review all professional recommendations of the Medical Staff regarding appointments and reappointments of staff members whenever the Governing Body's decision regarding such matters differs from the Executive Committee's recommendations. After such review, it shall submit its recommendations to the Executive Committee and the Governing Body. Thereafter, the decision of the Governing Body shall be final.

3. The purpose of this committee is to consider issues of medical and administrative importance such as: professional criteria for selection, evaluation, and retention of key personnel in such areas as administration, Medical Director, nursing service and similar positions.

4. Meetings: The Joint Conference Committee shall meet whenever necessary and shall transmit written reports of its activities to the Executive Committee and the Governing Body.

Section 10 – Medical Staff Committee

a. The members of the Medical Staff Committee shall be all members of the Active Medical Staff and shall be chaired by the President of the Medical Staff Committee. All members of this committee are voting members.

b. The purpose of this committee shall be to problem solve for all areas of concern regarding medical or psychiatric treatment of patients by the facility, to review policy and procedure, and recommend adoption by the Executive Committee, and to conduct other duties as determined pertinent by the Committee.

c. Meetings:

   1. The Medical Staff Committee shall meet at least monthly.

   2. The Medical Staff Committee meeting preceding the close of the Medical Staff year shall be the annual staff meeting at which election of officers for the ensuing period shall be conducted. The Medical Staff year shall begin July 1st of each year and end on June 30th of the following year.

ARTICLE XI: MEETINGS OF THE COMMITTEES OF THE MEDICAL STAFF

Section 1 – Regular Meetings

a. Regular general Medical Staff Services Committee meetings shall be held quarterly to review and evaluate the performance of staff and to consider and act upon committee reports. The Services Committees of the Medical Staff are: Executive, Continuous Quality Improvement, Morbidity and Mortality, Utilization Review, Infection Control, Pharmacy and Therapeutics, Credentials, and Joint Conference.

Section 2 – Special Meetings

a. The President of the Medical Staff Committee or the Executive Committee may call a special meeting of a Medical Staff Services Committee at any time. The President of the Medical Staff must call a special meeting within fourteen (14) days after a receipt of a written request for same signed by not less than one-fourth of the Active Medical Staff and stating the purpose of such meeting. The Executive Committee shall designate the time and place of any special meeting.

b. Written or printed notice stating the place, day, and hour of any special meeting shall be delivered, either personally or by mail, to each member of the Active Staff not less than five (5) nor more than fifteen (15) days before the date of such meeting by, or at the discretion of, the President of the Medical Staff or other persons authorized to call the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage paid, in the United States mail addressed to each staff member's address as it appears on the records of the facility. Notice may also be given to members of other Medical Staff categories who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3 – Agenda

a. The agenda at any regular general Medical Staff Committee Meeting shall be:

1. Call to order.
2. Approval of the agenda.
3. Approval of minutes of previous regular meeting and any special meetings held since previous regular meeting.
4. Communications.
5. Old business.
6. Medical Director's report.
7. President of the Medical Staff's report.
8. Reports of Medical Staff Services Committees.
9. New business (including elections when appropriate).
10. Summary of the Continuous Quality Improvement activities.
11. Adjournment.

b. The agenda at special meetings shall be:

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

c. The agenda at Medical Staff Services Committee meetings shall be:

1. Call To Order.
2. Approval of Agenda.
3. Approval of Minutes of past meetings.
4. Communications.
5. Old Business.
6. New Business.
7. Adjournment.

Section 4 – Special Attendance Requirements

A practitioner whose patient's clinical course is scheduled for discussion at a regular medical staff meeting shall be notified and shall be expected to attend such meeting. Whenever apparent or suspected deviation from clinical practice is involved, the notice to the practitioner shall so state,

15. To periodically evaluate facility systems for disposal of liquid and solid wastes.

16. To evaluate ventilation patterns in all areas of the facility especially seclusion areas.

17. To take corrective action as indicated by its own reviews and by the Quality Assurance Program of the facility.

c. Meetings: The Infection Control Committee shall meet at least quarterly.

Section 8 – Continuous Quality Improvement Committee

a. Composition: Voting membership shall include one member of the Active Medical Staff, Local Mental Health Director or designee; Medical Director, Director of Mental Health Nursing, Medical Records Supervisor, Deputy Director of Inpatient Services, and Continuous Quality Improvement Coordinator. Multi-disciplinary consulting allied staff will be used as required by State Department of Mental Health.

b. Duties:

1. To assure coordination and integration of all quality assurance activities.

2. To identify, assess, and prioritize problem areas which have potential for improvement.

3. To suggest solutions for problems to appropriate facility authorities and committees.

4. To monitor and evaluate the results of problem solving activities.

5. To perform certain special reviews, in a search for recurring problems of patient care delivery, as required by the Quality Assurance Program such as: liability claims, adverse effects, incident reports, complaints and suggestions.

6. Peer review

7. To evaluate the Quality Assurance Program annually.

8. To report on quality assurance activities to the Executive Committee, and the Governing Body.

c. Meetings: The Continuous Quality Improvement Committee shall meet at least quarterly.

Inpatient Mental Health Services Committee (a sub-committee of the Continuous Quality Improvement Committee)

a. Composition: Members shall include two (2) members of the Active Medical Staff, Inpatient Deputy Director, the Director of Nurses, the Director of Social Services, and the staff Social Worker.

b. Duties:

Committee for further review and recommendation within fourteen (14) days, and shall include in such notice of its decision a statement that a final decision will not be made until the Joint Conference Committee's recommendation has been received. At its next meeting after receipt of the Joint Conference Committee's recommendation, the Governing Body shall make its final decision, with like effect and notice as first above provided in this Section 7.

b. Notwithstanding any other provision of these bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Executive Committee or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both.

ARTICLE IX: OFFICERS

Section 1 – Officers of the Medical Staff

The officers of the Medical Staff shall be: President of the Medical Staff and the Medical Director.

Section 2 – Qualifications of Officers

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain status shall immediately create a vacancy in the office involved.

Section 3 – Election of Officers

a. The Medical Staff President shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote.

b. The nominating committee shall consist of three members of the Active Medical Staff appointed by the President of the Medical Staff.

c. Nomination may also be made from the floor at the time of the annual meeting.

d. In the event one candidate does not receive a majority on the first ballot, the candidate receiving the fewest votes will be eliminated from each processing state until a majority of votes is obtained by one candidate.

e. The Medical Director shall be appointed by the Governing Body on the recommendation of the Local Mental Health Director.

f. The Medical Director shall not hold the office of President of the Medical Staff.

Section 4 – Term of Office

All officers excepting the Medical Director shall serve a two (2) year term from their election date or until a successor is elected. Officers shall take office on the first day of the Medical Staff year. The Medical Director shall serve as long as the Governing Body continues the appointment.

Section 5 – Vacancies in Office

Vacancies in elective office during the Medical Staff year shall be filled through election by the Medical Staff.

Section 6 – Duties of Officers

a. The president of the Medical Staff shall:

1. Act in coordination and cooperation with the Medical Director and Local Mental Health Director in all matters of mutual concern within the facility.

2. Call, preside over, and be responsible for the agenda of all general meetings of the Medical Staff.

3. Serve as Chair of the Executive Committee.

4. Serve as ex-officio member of all other Medical Staff committees without vote.

5. Be responsible for the enforcement of Medical Staff bylaws, rules and regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

6. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body, the Medical Director, and the Local Mental Health Director.

7. Receive and interpret the policies of the Department of Health and Human Services to the Medical Staff and report to the Local Mental Health Director on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

8. Be responsible for the educational activities of the Medical Staff.

9. Act as a spokesman for the Medical Staff in its external professional responsibilities.

10. Appoint chairs and members of all Medical Staff Committees.

11. Establish and appoint members to special committees.

b. The Medical Director shall:

1. Act on behalf of the Local Mental Health Director in the overall professional management of the facility.

2. Advise the Local Mental Health Director and the facility administration concerning professional management of the facility.

3. Attend standing committee meetings as defined in Article X of these bylaws and coordinate the activities of the committee.

4. Enforce all Medical Staff bylaws, rules and regulations.

5. Enforce disciplinary actions against members of the Medical Staff after proper consideration of such actions according to these bylaws, rules and regulations.

Section 7 – Removal of Elected Officers

Removal of elected Medical Staff officers may be initiated by a two-thirds majority of voting members of the Medical Staff. Such removal shall not be effective unless ratified by the Executive Committee and by the Local Mental Health Director. Should such ratification fail, the matter shall be referred to the Joint Conference Committee at a special meeting for appropriate action. The Joint Conference Committee shall meet without the presence of the Medical Staff officer whose removal has been requested, but the Medical Staff officer shall be given an opportunity to appear before the committee if so desired. After considering the recommendations by this committee, the Governing Body shall make a decision which shall be final.

ARTICLE X: STANDING COMMITTEES

Section 1 – Committee Structure

a. There shall be two (2) basic types of standing committees of the Medical Staff: permanent and special.

b. Standing committees are those committees established by these bylaws which function throughout the year and automatically continue to function during each Medical Staff year. The standing committees are Medical Staff Committee, Executive Committee, Credentials Committee, Utilization Review Committee, Pharmacy and Therapeutics Committee, Infection Control Committee, Continuous Quality Improvement Committee, and Joint Conference Committee.

c. Special committees are those committees established by the President of the Medical Staff to serve such functions and perform such duties as the President of the Medical Staff may direct. Special committees shall report to the Executive Committee, and they shall automatically be dissolved upon completion of their duties and functions. Members of special committees shall be appointed by the President of the Medical Staff.

Section 2 – Committee Meetings and Reports

a. Regular Meetings – Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

b. Special Meetings – A special meeting of any committee may be called at the request of the chair of the committee, by the President of the Medical Staff, or by one-third of the committee's members, but not less than two (2) members.

c. Notice of Meetings – Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee not less than twenty-four (24) hours before the time of such meeting, by the person or persons calling the meeting.

d. Quorum – Fifty (50) percent of a committee, but not less than two (2) members, shall constitute a quorum at any meeting. Ex-officio members of a committee shall not be counted in determining the existence of a quorum.

e. Minutes – Minutes of each regular and special meeting of a committee shall be prepared. Minutes shall include: a record of the attendance of members, findings, conclusions, recommendations and actions taken on each matter. The minutes shall be approved and signed by the chair and are available in the Medical Staff Coordinator's office for review.

After approval has been obtained, contents of minutes shall be forwarded to the Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting, and copies shall be transmitted to the Continuous Quality Improvement Committee through the Quality Assurance Coordinator.

f. Attendance Requirements – Committee members are expected to attend all committee meetings, unless excused for an acceptable cause by the committee chair. Each committee member shall be required to attend not less than fifty (50) percent of all committee meetings in each year. The failure to meet the foregoing annual attendance requirements, unless excused by the committee chair for good cause shown, shall be grounds for corrective action.

g. Procedural Rules – Robert's Rules of Order shall be used as the guideline for rules of procedure in all Medical Staff meetings.

h. Annual Report – Each standing committee shall prepare an annual report detailing its goals and accomplishments, in a format determined by the President of the Medical Staff, to be submitted to the President of the Medical Staff for presentation at the annual meeting of the Medical Staff and the Executive Committee.

Section 3 – Executive Committee

a. Composition: The Executive Committee membership shall consist of the President of the Medical Staff, the Medical Director, the Deputy Mental Health Director for Administration, the Deputy Mental Health Director of Sempervirens, two (2) additional members of the Medical Staff, and the Local Mental Health Director. Physicians must be in the majority. The president of the Medical Staff shall serve as chair.

b. Duties:

1. To represent and to act on behalf of the Medical Staff regarding issues of importance to the provision and quality of patient care.

2. To coordinate the activities and general policies of the facility.

3. To receive and act upon committee reports.

4. To implement policies of the Medical Staff.

5. To provide liaison between the Medical Staff and the Medical Director, the Local Mental Health Director, and the Governing Body.

6. To make recommendations on facility management matters to the Governing Body through the Local Mental Health Director.

7. To fulfill the Medical Staff's responsibility to the Governing Body for the medical care rendered to patients in the facility.

8. To ensure the Medical Staff is informed of the accreditation status of the facility.

9. To review the credentials of all applicants for staff membership and delineation of clinical privileges.

10. To periodically review all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges.