HUMBOLDT COUNTY
BEHAVIORAL HEALTH

BYLAWS
OF
MEDICAL STAFF

Last Revision: 08-30-2021

APPROVED BY: GOVERNING BODY (BOS) on September 2, 2021

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MISSION STATEMENT

To reduce poverty and connect people and communities to opportunities for health and wellness

PREAMBLE

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

WHEREAS, the behavioral health inpatient services (i.e., Sempervirens, Humboldt County Correctional Facility, Juvenile Hall, Regional Facility) and outpatient services are provided under medical supervision; and

WHEREAS, it is recognized that the quality of medical care for Humboldt County Behavioral Health 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 department's obligations to its patients.

THEREFORE, the physicians practicing in the inpatient and outpatient mental health services 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 DHHS Behavioral Health Medical Staff.

ARTICLE II: PURPOSES AND ORGANIZATIONS

Purposes

The purposes of organization are:

a. The Medical Staff of the Department of Health and Human Services (hereinafter may be referred to as "DHHS") Behavioral Health (i.e., inpatient and outpatient) is dedicated to the accomplishment of the department's mission, stated as:

   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 department'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.

b. To ensure that all patients admitted to or treated in any component of behavioral health services, receive appropriate medical care.

c. 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 at DHHS Behavioral Health, through the appropriate delineation of the clinical privileges that each practitioner may exercise through an ongoing review and evaluation of each practitioner's performance.

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

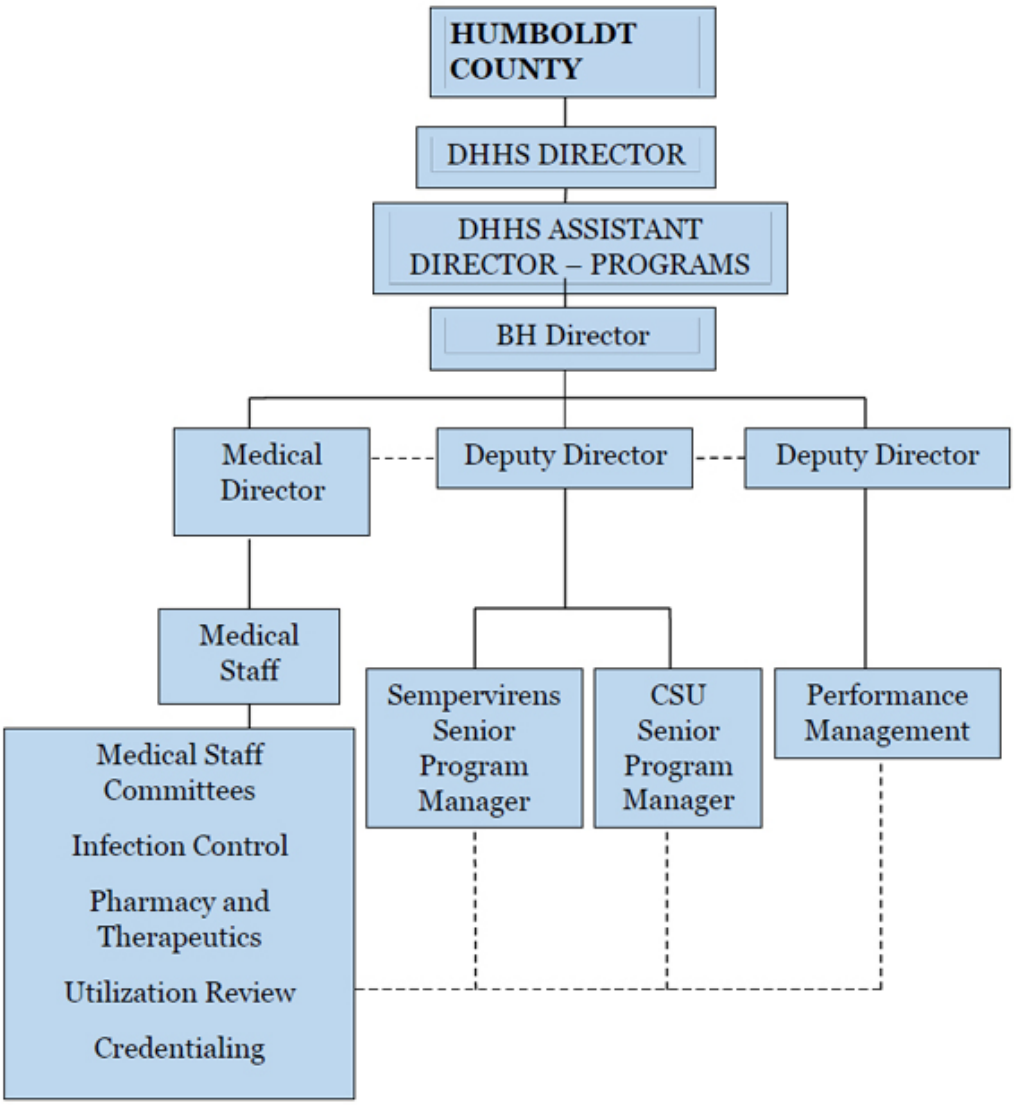
e. To initiate and maintain rules and regulations for the proper functioning of the Medical Staff in accordance with 22 CCR 77081.

f. To provide a means whereby issues and quality assurance activities concerning the Medical Staff and behavioral health services may be discussed by the Medical Staff with the Governing Body and the Medical Director, through the Joint Conference Committee.

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

h. 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 DHHS Behavioral Health is not a right but a privilege. Inpatient practice may be extended only to professionally competent physicians while outpatient practice may be extended to professionally competent physicians, physician assistants, and/or nurse practitioners. All must continuously meet the qualifications, standards, and requirements set forth by these bylaws. Only inpatient practitioners who are duly appointed shall have clinical privileges and the right to admit patients to Sempervirens psychiatric health facility (hereinafter referred to as "Sempervirens" or "SV"). The Humboldt County DHHS Behavioral Health 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 or expiration/cancellation of contract.

Section 2 – Qualifications for Membership

a. General Qualifications

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

All applicants must:

1. Document their (1) current California licensure, (2) adequate experience, education and training through an accredited psychiatric residency, (3) current adequate physical and behavioral 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, (4) not listed on any exclusions list, including but not limited to: OIG, GSA, DEA, Med Board of California (5) National Practitioner Data Bank, and (6) American Medical Association or Nursing Board of California or Physician Assistant Board of California.

2. 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;

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

4. 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. Physicians are required to obtain the appropriate amount of CMEs (continuing medical education credits) per year as required by their respective state organizations.

5. 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). A Nurse Practitioner must have a collaborative agreement with at least one MD or DO on staff. Both Physician Assistants and Nurse Practitioners must have sufficient continuing educational credits as required by their respective state organizations.

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 department, established by the Medical Staff as approved by the Governing Body.

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

d. Prepare and complete in a timely manner all documentation for which they are responsible as outlined in the respective program's documentation manuals.

e. Abide by professional ethical principles of the department 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 department.

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 department.

h. Active Medical Staff and Temporary Staff comprised of licensed physicians, physician assistants, and nurse practitioners must undergo all training requirements as mandated by the Behavioral Health Director, Medical Director and the Senior Program Manager of Performance Management. All training requirements must be completed within 30 days of request.

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 and Executive Committee as provided in these bylaws. 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 are for a maximum period of two (2) years. The Medical Director may grant provisional status for the practitioner to start working on Sempervirens or in an outpatient capacity. Upon approval by the Credentialing Committee, SV-CQI, Executive Committee and by the Board of Supervisors at the Joint Conference Committee, this will change to an active status.

c. Reappointments, which are also for a maximum of two (2) years, will take place at the end of the second year. If the Behavioral Health Director, Medical Director and Credentialing Committee agree based on the reappointment process, the practitioner's active status will continue. If there is disagreement by any of these entities, or by the Board of Supervisors, the practitioner's status will change to an interim status until the issue is resolved.

d. Reappointment will be 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.

e. 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, maintenance of continuing medical education, adherence to medical staff rules, certifications, licensure, and compliance with current licensure requirements.

f. 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 DHHS Behavioral Health Medical Staff.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 1 – The Medical Staff

The Medical Staff shall include Active Staff and Consulting Medical Staff.

Section 2 – Active Medical Staff

The Active Medical Staff shall consist of physicians, physician assistants, and nurse practitioners who are employed or contracted to care for patients at DHHS Behavioral Health, 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 able to attend Medical Staff meetings when in Humboldt County. 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, physician's assistants, and clinical psychologists, who provide for physical examinations, other medical needs, or psychiatric/psychological services on a consulting basis for DHHS Behavioral Health. They may not attend Medical Staff meetings and may not vote on any Medical Staff matter. Medical Staff will periodically appraise the privileges of the Consulting Medical Staff.

Section 4 – Temporary Medical Staff

The Temporary Staff consists of Locum Tenens, Extra-Help, licensed physicians, licensed physicians' assistants, licensed nurse practitioners or licensed prescribers who are placed with a preceptor associated with an educational institution of which the County is contracted with 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 or Behavioral Health Director or their designee."

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. Affiliation letters will be requested to determine 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. However, due to the poor return-rate on these letters, failure to receive these will not automatically stop the practitioner from working at DHHS.

b. 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 regarding the application. The applicant shall sign a Release of Information and, by doing so, the applicant authorizes the department 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 department'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. The applicant further releases from any liability, to the fullest extent permitted by law, all representatives from the department, 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 all approved applicants will view an assigned training on the DHHS Behavioral Health bylaws, rules and regulations within 1 month of approval for the Medical Staff and agree to be bound by the terms of the DHHS BH bylaws, rules and regulations.

Section 2 – Appointment Process

a. After receiving completed applications for new staff membership, the Medical Director, or their designee, may grant provisional privileges to applicants to the Medical Staff while their applications are being considered by committees and the Governing Body in accordance with Article VI, Section 1. Clinical privileges shall be delineated and monitored in accordance with Article VI of these bylaws. Provisional privileges granted in this manner may be suspended at any time pending final action by department 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.

b. Upon receipt of the completed application for membership, the Credentials Committee shall make a determination of acceptance for appointment after examining all evidence of the character, professional competence, qualifications, and ethical standards of the practitioner. This determination will be forwarded to SV-CQI and the Executive Committee.

c. At its next regular meeting, after receipt of the application and the report and recommendation of the Credentials Committee and SV-CQI, 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 Medical Director shall submit this opinion to the Joint Conference Committee for final approval by the Governing Body.

f. When the recommendation of the Executive Committee is averse to the practitioner, either in respect to appointment or clinical privileges, the Medical Director 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 Medical Director shall promptly notify the practitioner, by certified mail, return receipt requested. The Medical Director shall also forward such recommendation to the Behavioral Health Director, but the Behavioral 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 Medical Director 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 Behavioral 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 Director's administrative secretary, Behavioral Health Director, and Medical Director. The Medical Director 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 Medical Director.

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 of due date, the completed forms shall be returned to the Medical Director's Executive Secretary. Failure, without good cause, to return all completed reappointment forms within that time frame will result in suspension of clinical privileges until this is completed. This includes completion of all training requirements.

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). Applications for reappointment 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 the following: such member's professional competence and clinical judgment in the treatment of patients, ethics, conduct, attendance at required meetings, and participation in staff affairs, compliance with the Medical Staff Bylaws, Rules and Regulations, cooperation with department personnel, relations with other practitioners, and general attitude toward patients, the department 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 Behavioral Health Director for its decision which shall be final.

f. A medical 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 department where the Staff practices.

ARTICLE VI: CLINICAL PRIVILEGES

Section 1 – Provisional Privileges

a. Provisional privileges may be granted to properly licensed practitioners who are applicants for active medical staff membership and awaiting appointment.

b. The Medical Director and/or the Behavioral Health Director may approve provisional privileges to all practitioners. All inpatient physicians must also have specific clearance to work in these sites. However, inpatient physicians, whose site clearance is pending, may attest that they have no prior administrative actions, criminal convictions, or violations of any licensing laws or regulations by signing the Medical Director's attestation form, which will then allow them to work on the inpatient unit until their site clearance is obtained.

c. Practitioners granted provisional privileges may have their privileges summarily suspended or further restricted at any time by the Behavioral Health Director, Medical Director, or the Governing Body.

d. Practitioners granted such provisional 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.

Section 2 – Clinical Privileges Restricted

a. Every practitioner practicing at this department 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 for 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 department 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.

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. Any Medical Staff receiving a complaint, should report the complaint to his/her supervisor to evaluate and/or initiate the corrective action procedure. Members of the Medical Staff who wish to make a complaint about another member of the Medical Staff, shall likewise report the complaint to his/her supervisor. If Medical Staff wish to make a complaint against a supervisor, the complaint may be lodged with the Quality Improvement Coordinator. 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 department 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; and/or (v) below applicable professional standards. A corrective action against such practitioner may be requested by the chair of any standing committee of the Medical Staff, by the Medical Director, Behavioral 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 it taking action on such request at the next scheduled meeting. 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 Behavioral 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 Behavioral 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 Medical Director and Behavioral Health Director, in writing, of all requests for corrective action received by the Credentials Committee and shall continue to keep the Medical Director and the Behavioral 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 Behavioral 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 has, before the suspension, made reasonable attempts to contact the Executive Committee. A suspension by the Governing Body 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 department.

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.

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. 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 Medical Director or the Behavioral Health Director shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the department 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 Behavioral 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

Corrective action for Consulting Staff may be initiated by the Credentials Committee, the Medical Director, or supervising practitioners. Should such action result in a reduction or suspension of privileges, the consulting 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 DHHS Behavioral Health Medical Staff.

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. 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 Medical Director 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. Notice shall be given by certified mail, return receipt requested. The practitioner may, by written notice to the Medical Director by certified mail, return receipt requested, request a hearing. Written notice requesting a hearing shall be deemed received by the Department as of the day the return receipt is signed by any staff member of the Department.

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 receipt of the written notice of an adverse recommendation or decision, 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 receiving a request 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 Medical Director, 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 practitioner's 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) available members of the Medical Staff in consultation with the Executive Committee. The Medical Director or designee appointed by the Behavioral Health Director shall serve 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 is held that is 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. In the event the vote results in a tie, the Behavioral Health Director shall be permitted to cast a tie-breaking vote.

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. Any witnesses shall be excluded from the hearing when they are not testifying. The hearing shall be confidential and closed to the public in order to protect the affected practitioner's confidential employment information, and the confidential nature of the underlying facts at issue.

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 Behavioral Health Director, when their action has prompted the hearing, shall appoint the Medical Director and/or some other Medical Staff member to represent them 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. 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 Behavioral 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 Behavioral 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 report will be sent to the practitioner via certified mail as soon as administratively practicable. The practitioner shall have ten (10) days after receipt of the report and record from the hearing, to submit a written statement on his or her own behalf. The written statement shall state the factual and procedural matters with which there is disagreement, along with the specific reasons for such disagreement. 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 Behavioral 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 Medical Director 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 the 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 Behavioral 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 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 – Officer of the Medical Staff

The officer of the Medical Staff shall be the Medical Director.

Section 2 – Qualifications of Officer

a. The Medical Director must have completed an accredited psychiatric residency.

b. Breadth and depth of knowledge and experience are desirable, but the position should be filled based on the recommendations of the past Medical Director, when possible, and after considering the qualifications of interested applicants, a review of the Medical Director job description, and ability to meet the clinical and administrative demands of the position as determined by the applicant's interviews.

c. Ability to view, discuss, and find solutions utilizing a team perspective when appropriate.

d. The applicant should have significant skills in relationship building.

e. The applicant should be willing to work with other County institutions and practitioners in furthering our goals to provide enhanced patient care.

f. The applicant should exemplify positive character attributes in all their work activities.

Section 3 – Term of Office

The Medical Director shall serve as outlined in their contract or upon an appointment by the Behavioral Health Director. The Medical Director shall serve as long as the Behavioral Health Director and Governing Body continues the appointment.

Section 4 – Vacancies in Office

Vacancy in the office of Medical Director shall be filled by contract agreement. The Behavioral Health Director must approve the appointment of the Medical Director.

Section 5 – Duties of the Medical Director

a. The Medical Director shall:

1. Act in coordination and cooperation with the Behavioral Health Director in all matters of mutual concern within the department.

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

3. Serve as Co-Chair of the Executive Committee.

4. 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.

5. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and the Behavioral Health Director.

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

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

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

9. Appoint members of all Medical Staff Committees in consultation with the Behavioral Health Director.

10. Establish and appoint members to special committees in consultation with the Behavioral Health Director.

11. Act on behalf of the Behavioral Health Director in the overall professional management of the department.

12. Advise the Behavioral Health Director and the department administration concerning professional management of the department.

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

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

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

Section 6 – Removal of the Medical Director

Removal of the Medical Director may be initiated by the Behavioral Health Director. If any Humboldt County Behavioral Health (hereinafter may be referred to as "HCBH") staff member believes the Medical Director should be removed, their concern should be shared with the Behavioral Health Director. The Behavioral Health Director will then choose a course of action based on the concern, consistent with the employment contract provisions or in consultation with Employee Services.

ARTICLE X: STANDING COMMITTEES

Section 1 – Committee Structure

a. There shall be three (3) types of committees of the Medical Staff: permanent, special and temporary.

b. Permanent 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, Morbidity and Mortality Committee, Utilization Review Committee, Pharmacy and Therapeutics Committee, Infection Control Committee, Continuous Quality Improvement Committee, and Joint Conference Committee. Members of permanent committees not specifically identified will be appointed or invited by the identified chair as designated herein.

c. The Joint Conference Committee shall have open and public meetings in compliance with Government Code §§54950 - 54963 [Ralph M. Brown Act] With the exception of the Joint Conference Committee, all permanent committees meet to discuss issues related to patient safety, quality improvement/assurance and/or involve peer review, are therefore closed to the public, and subject to notice requirements only as defined herein [Health & Safety Code §1461; Health & Safety Code §32155 & Government Code §37624.3].

d. Special committees, such as a County Psychiatry Committee, are those committees that may be established by the Medical Director independent of these bylaws. Members of special committees shall be appointed by the Medical Director or Behavioral Health Director, and are not subject to Government Code §§54950 - 54963 [Ralph M. Brown Act].

e. Temporary committees (also referred to as "ad hoc" committees) may be established by the Medical Director or Behavioral Health Director, as needed, to advise on a limited or single issue. Temporary committees shall report to the Executive Committee and shall automatically be dissolved upon completion of their duties and functions. Members of temporary committees shall be appointed by the Medical Director or Behavioral Health Director. Temporary committees with 2 or fewer County Supervisors as members, are not required to comply with Government Code §§54950 - 54963 [Ralph M. Brown Act].

Section 2 – Committee Meetings and Reports

a. Regular Meetings – Committees may decide the time and place for holding regular meetings.

b. Special Meetings – A special meeting of any committee may be called at the request of the Medical Director or Behavioral Health Director.

c. Notice of Meetings – Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting 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.

e. Minutes – Minutes of each regular and special meeting of a committee shall be prepared by either the Executive Secretary, Quality Improvement (hereinafter may be referred to as "QI") personnel or designee. Minutes may include: a record of attendance, findings, conclusions, and/or action items. The minutes shall be sent to those who attended the meeting. All attendees will have 5 days to suggest edits or additions to the meeting minutes. They will then be approved by the Medical Director. They will be available by request to the Medical Director's Executive Secretary. The Executive Secretary will maintain a permanent digital file of these meeting minutes.

f. Attendance Requirements – Committee members are expected to attend as many committee meetings as possible. Failure to meet this goal, unless excused by the committee chair for good cause shown, shall be grounds for corrective action.

g. Procedural Rules – Robert's Rules of Order may be used as a guideline for rules of procedure in these meetings or any other format at the discretion of the meeting chair.

h. Annual Report – Each standing committee's information will feed into CQI and the Executive Committee Meeting.

Section 3 – Executive Committee

a. Composition: Membership shall consist of:

1. Medical Director, who shall serve as co-chair
2. Behavioral Health (hereinafter may be referred to as "BH") Director or designee
3. Deputy Behavioral Health Director, who shall serve as co-chair
4. QI Coordinator
5. Hospital Administrator
6. Director of Nursing
7. Medical Director Executive Secretary & Credentialing Coordinator

b. Duties are to provide a broad update to the committee on:

1. Audit Update
    i. Department of Health Care Services (hereinafter referred to as "DHCS")
    ii. Centers for Medicare and Medicaid Services (hereinafter referred to as "CMS")
2. Bylaw Update
3. Credentialing Update – Review applicants for initial appointment and Providers due for reappointment. Committee reviews:
    i. Redacted application
    ii. Request for Medical Staff Privilege form – to be signed by Executive Committee chair or designee
    iii. Medical Board of California report
    iv. Current Drug Enforcement Administration Registration
4. CQI Overview
    i. Work Plan
    ii. Subcommittee Meeting Update
    iii. SV Contractor Review
5. SV Policy and Procedure Update

This information should represent a broader summary of that obtained via the monthly and quarterly inpatient committee meetings.

It should be used in preparation for, and feed into, the agenda for the Joint Committee Meeting involving the Board of Supervisors.

It should be used as a general overview of all inpatient activities, policies, and concerns and be used to brainstorm future short- and long-term goals to enhance the quality and efficiency of SV for both patients and staff.

c. Meeting Frequency: The Executive Committee meets as a virtual committee through MD Staff. The Executive Secretary sends items for review to committee members. After reviewing documents, committee members complete a Pronto Survey to approve and recommend that the

applicant be reviewed at next committee level. If applicant is not approved, committee members will meet to discuss. Pronto Survey is electronically stored in applicant's electronic record.

Section 4 – Credentials Committee

a. Composition: Membership shall consist of:

1. Medical Director, who shall serve as chair
2. Medical Staff Member - #1
3. Medical Staff Member - #2

b. Duties:

1. Review all providers requiring credentialing or reappointment
2. As much of the following will be used in the review process as possible:
    i. Redacted application
    ii. CV (Initial appointment only)
    iii. Request for Medical Staff Privileges form – to be signed by Credentials Committee chair or designee
    iv. Medical Board of California License report
    v. Current Drug Enforcement Administration Registration
    vi. Incident Reports – Reappointment only
    vii. Grievances – Reappointment only
    viii. Chart Review/Corrective actions – Reappointment only
    ix. Peer review – Reappointment only
3. Reappointment occurs every 2 years
4. To review the credentials of all applicants and to make recommendations for either new or continued membership and delineation of clinical privileges to SV-CQI.
5. For those being credentialed for the first time, the Medical Director may allow prospective candidates who do not yet have Live Scan clearance, to work on Sempervirens in a provisional capacity if there is:
    i. Exclusion lists report with no deficiencies or concerns
    ii. Signed attestation of no prior administrative actions or criminal convictions taken against them at any federal, state, or local government agency. Also, that they have not violated any licensing laws or regulations, nor engaged in conduct that poses a risk to the health or safety of any client at facilities they have worked at.
    iii. The physician has completed the orientation process

c. Meeting Frequency:

1. The Credentials Committee meets as a virtual committee through MD Staff when practitioner is due for appointment or reappointment. The Executive Secretary sends items for review to committee members. After reviewing documents, committee members complete a Pronto Survey to approve and recommend that the applicant be reviewed at next committee level. If applicant is not approved, committee members will meet to discuss. Pronto Survey is electronically stored in applicant's electronic record.

Section 5 – Utilization Review Committee

a. Composition: Membership shall consist of:

    1. QI Coordinator, who shall serve as chair
    2. Medical Director
    3. Behavioral Health Director or designee
    4. Medical Staff member
    5. UR Coordinator
    6. Medical Records manager

b. Duties:

    1. Evaluate appropriateness of admissions to the Sempervirens, length of stay, discharge practices, use of medical and department services and all related factors which may contribute to the effective utilization of facility and physician services.
    2. Analyze how under-utilization and over-utilization of each of the department's services affect the quality of patient care and obtain criteria relating to average or normal lengths of stay by specific disease categories, and evaluate systems of utilization review employing such criteria.
    3. Ensure 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 department.
    4. Discuss how current problems in these areas may be improved.

c. Meeting Frequency: The Utilization Review Committee shall meet quarterly.

Section 6 – Pharmacy and Therapeutic Committee

a. Composition: Membership shall consist of:

    1. Medical Director, who shall serve as chair
    2. Medical Staff member
    3. Pharmacist
    4. IC Preventionist
    5. Director of Nursing
    6. QI Coordinator

b. Duties:

    1. Development and surveillance of all drug utilization policies and practices within the department in order to assure optimum clinical results and a minimum potential for hazard.

1. Serve as an advisory group on the current formulary.

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

3. Prevent unnecessary duplication in stocking drugs, and drugs in combination, that have identical amounts of the same therapeutic ingredients.

4. Evaluate clinical data concerning new drugs/preparations requested for use in the department.

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

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

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

8. 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. Meeting Frequency: The Pharmacy and Therapeutics Committee shall meet quarterly.

Section 7 – Infection Control Committee

a. Composition: Membership shall include:

1. Medical Director, who shall serve as chair

2. Behavioral Health Director or designee

3. Medical Staff member

4. IC Preventionist

5. Director of Nursing

6. QI Coordinator

b. Duties:

1. Define, classify, and report nosocomial infections.

2. Evaluate, record, and report infection among patients and employees.

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

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

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

6. Develop, revise, and conduct an employee health program.

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

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

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

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

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

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

13. Provide for necessary laboratory support of microbiological and serological nature.

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

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

16. Take corrective action as indicated by its own reviews and by the Quality Assurance Program of the department.

c. Meeting Frequency: The Infection Control Committee shall meet quarterly.

Section 8 – Inpatient Continuous Quality Improvement Committee (SV-CQI)

a. Composition:

1. QI Coordinator, who shall serve as chair

2. Medical Director

3. Behavioral Health Director or designee

4. Director of Nursing

5. Hospital Administrator

6. Behavioral Health Deputy Director

7. Medical Records Manager

b. Duties:

1. Ensure coordination and integration of all quality assurance activities.

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

3. Suggest solutions for problems to appropriate department authorities and committees.

4. Monitor and evaluate the results of problem-solving activities.

5. 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 will be completed by Medical Staff and/or Medical Director – components of Peer Review will be at the discretion of the Medical Director – Frequency and number of peer assessments on each physician will be at the discretion of the Medical Director

7. Evaluate the Quality Assurance Program annually.

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

9. Ensure that quality care is provided to Sempervirens patients.

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

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

12. To monitor and evaluate the results of problem-solving activities.

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

14. Provide relevant trainings and review training completion reports.

c. Meetings: SV-CQI will meet 10 times each year.

Section 9 – Joint Conference Committee

a. Composition: Membership shall consist of:

1. Behavioral Health Director, who shall serve as chair

2. Governing Body (2 from Board of Supervisors)

3. Medical Director

4. Behavioral Health Deputy Director

5. QI Coordinator

6. Hospital Administrator

b. Duties are to provide a broad update to the Board of Supervisors on:

1. Audit Update

2. DHCS

3. CMS

c. Bylaw Update

d. Credentialing Update

e. CQI Overview

    1. Work Plan

    2. Subcommittee Meeting Update

    3. SV Contractor Review

f. SV Policy and Procedure Update

This information should represent an overview of that obtained from the Executive Committee Meeting.

Meeting Frequency:

a. The Joint Conference Committee shall meet annually unless the Board of Supervisors Joint Conference Committee members request a written update of the above in lieu of a meeting.

b. If a written update will suffice, this will be provided by the Behavioral Health Director.

Section 10 – Medical Staff Committee

a. Composition:

    1. Medical Director, who shall serve as chair

    2. All available psychiatrists; inpatient and outpatient

b. Duties:

    1. Review and problem-solve all concerns regarding medical/psychiatric treatment patients

    2. Review treatment team processes

    3. Review and problem-solve all audit concerns

    4. Review and problem-solve all Electronic Health Record concerns

c. Meeting Frequency:

    1. The Medical Staff Committee shall meet at least 8 times per year.

Section 11 – Morbidity and Mortality Committee Meeting

a. Composition:

    1. Medical Director

    2. Medical Staff member #1

3. Medical Staff member #2

b. Duties:

1. Review all cases submitted by QI

2. Determine if there was a breach in the standard of care

3. If indicated, suggest processes to improve patient care

4. When possible, provide the opportunity to discuss Morbidity and Mortality (hereinafter referred to as "M&M") issues, and provide recommendations to any interested Medical Staff for purposes of edification and brainstorming ways of enhancing patient care.

5. The actual method of conducting M&M Committee Meetings will be left to the discretion of the Medical Director

c. Meeting Frequency: M&M meetings will be arranged as needed with the goal to complete each in a timely fashion.

ARTICLE XI: MEETINGS OF ALL STANDING COMMITTEES

Section 1 – Special Meetings

a. The Medical Director or the Executive Committee may call a special meeting at any time. The Medical Director 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 Medical Director 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 department. 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 2 – Agenda

a. Agenda formats shall be created in a manner acceptable to each Committee Chair.

Section 3 – 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, 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, may 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 Medical Director or by majority vote of the Executive Committee if the Medical Director is the practitioner involved, until not later than the next meeting; otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

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 department. 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 department.

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 BEHAVIORAL 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 Behavioral 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 Behavioral Health Director. In cases of emergency the Behavioral 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 Behavioral Health Director.

Notwithstanding any other provision of these Bylaws, the Behavioral Health Director or a physician designee should the Behavioral 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 Behavioral 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 DHHS BEHAVIORAL HEALTH INPATIENT MEDICAL STAFF RULES AND REGULATIONS

1. All orders for treatment shall be in writing or in Order Entry in the electronic medical record . 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, physician assistants, or nurse practitioners who have been duly appointed to the Medical Staff and have obtained permission from the psychiatrist on duty at Sempervirens.

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 and shall be signed and dated by the patient and appropriate disciplines as outlined in policy.

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

8. Medication advisement (i.e., Medication Consent) shall be completed for every prescription provided for patients as outlined in policy.

9. Only licensed psychiatrists 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. Physician assistants and nurse practitioners may initiate restraints and seclusions as applicable law and policy permit.

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 psychiatrists, physician assistants and nurse practitioners shall be required to have current CPR certification.

12. Prior to transfer into Sempervirens, the admission of all patients must be approved by the SV psychiatrist or his or her designee after directly communicating with the transferring provider(s).

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

14. For any transfers out of Sempervirens, the SV psychiatrist or his/her designee will communicate with the accepting provider before the transfer.

15. 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 completed within thirty (30) days of discharge and will be out of compliance after this date. Charting completions for patients discharged from Sempervirens will be out of compliance if not done within thirty (30) days of discharge.