AGENDA

REGULAR MEETING OF THE BOARD OF DIRECTORS
Tuesday, May 5, 2020 – 4:30 PM

IN AN EFFORT TO PREVENT THE SPREAD OF COVID-19 (CORONAVIRUS), AND IN ACCORDANCE WITH THE GOVERNOR'S EXECUTIVE ORDER N-29-20, THERE WILL BE NO PUBLIC LOCATION FOR ATTENDING THIS BOARD MEETING IN PERSON. MEMBERS OF THE PUBLIC MAY JOIN THE MEETING BY FOLLOWING THE INSTRUCTIONS BELOW:

Meeting Information

Meeting link:

https://sangorgoniomemorialhospital-ajd.my.webex.com/sangorgoniomemorialhospital-ajd.my/j.php?MTID=m082e148333086be213bd01ab8f3ad92d

Meeting number: 291 099 431

Password: 1234

More ways to join

Join by video system

Dial 291099431@sangorgoniomemorialhospital-ajd.my.webex.com

You can also dial 173.243.2.68 and enter your meeting number.

Join by phone

+1-510-338-9438 USA Toll

Access code: 291 099 431

Emergency phone number if WebEx tech difficulties

951-846-2846

code: 3376#

THE TELEPHONES OF ALL MEMBERS OF THE PUBLIC LISTENING IN ON THIS MEETING MUST BE "MUTED".

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Administration Office at (951) 769-2160. **Notification 48 hours prior to the meeting** will enable the Hospital to make reasonable arrangement to ensure accessibility to this meeting. [28 CFR 35.02-35.104 ADA Title II].

San Gorgonio Memorial Hospital
Board of Directors Regular Meeting
May 5, 2020

			TAB
I.	Call to Order	S. DiBiasi, Chair	
II.	Public Comment		

> Members of the public who wish to comment on any item on the agenda may submit comments by emailing publiccomment@sgmh.org on or before 1:00 PM on Tuesday, May 5, 2020, which will become part of the board meeting record.

EDUCATION

III.	COVID-19 Presentation	K. Singh, MD	A

OLD BUSINESS

IV.	***Proposed Action - Approve Minutes** • April 7, 2020 regular meeting	S. DiBiasi	B

NEW BUSINESS

V.	Healthcare District Board meeting report - informational	D. Tankersley	verbal
VI.	COVID-19 Alternate Board Processes	S. DiBiasi	C
VII.	Hospital Board Chair monthly report	S. DiBiasi	D
VIII.	May, June & July Board/Committee meeting calendars	S. DiBiasi	E
IX.	CEO monthly report	S. Barron	verbal
X.	*** Proposed Action – Discussion/Approval of anesthesia agreement** ▪ **ROLL CALL**	S. Barron	F
XI.	*** Proposed Action – Approve Resolution #2020-03** Designation of Applicant's Agent Resolution for Non-State Agencies		G
XII.	Bi-monthly Patient Care Services report		H

XIII. *** Proposed Action – Approve Community Health Improvement Plan** — I
- **ROLL CALL**

XIV. Foundation monthly report — J

XV. Committee Reports:

- Finance Committee — O. Hershey
  - April 28, 2020 - no meeting due to technical difficulties — K

  *** Proposed Action – Approve March 2020 Financial Statement**
  (approval recommended by Finance Committee 04/28/2020)
  - **ROLL CALL**

XVI. Chief of Staff Report — S. Hildebrand, MD, Chief of Staff — L
*** Proposed Action - Approve Recommendations of the Medical Executive Committee**
- **ROLL CALL**

XVII. *** Proposed Action - Approve Policies and Procedures** — Staff — M
- **ROLL CALL**

XVIII. Community Benefit events/Announcements/ and newspaper articles — S. DiBiasi — N

***** ITEMS FOR DISCUSSION/APPROVAL IN CLOSED SESSION** — S. DiBiasi

- Proposed Action - Approve Medical Staff Credentialing
  (Health & Safety Code §32155; and Evidence Code §1157)
- Receive Quarterly Performance Improvement Committee report
  (Health & Safety Code §32155)
- Receive Quarterly Environment of Care/Life Safety/Utility Management report
  (Health & Safety Code §32155)
- Receive Quarterly Security/Safety and Emergency Preparedness report
  (Health & Safety Code §32155
- Receive Quarterly Corporate Compliance Committee report
  (Health & Safety Code §32155

XIX. **ADJOURN TO CLOSED SESSION**

*** The Board will convene to the Open Session portion of the meeting approximately 2 minutes after the conclusion of Closed Session.**

RECONVENE TO OPEN SESSION

*** **REPORT ON ACTIONS TAKEN DURING CLOSED SESSION** S. DiBiasi

XX. Future Agenda Items

XXI. **ADJOURN** S. DiBiasi

***Action Required**

In accordance with The Brown Act, *Section 54957.5*, all public records relating to an agenda item on this agenda are available for public inspection at the time the document is distributed to all, or a majority of all, members of the Board. Such records shall be available at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

<u>Certification of Posting</u>

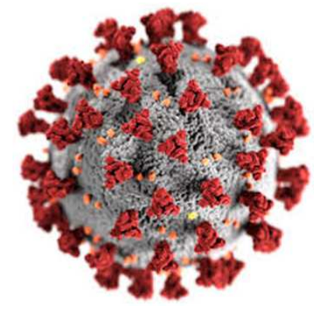
I certify that on May 1, 2020, I posted a copy of the foregoing agenda near the regular meeting place of the Board of Directors of San Gorgonio Memorial Hospital, and on the San Gorgonio Memorial Hospital website, said time being at least 72 hours in advance of the regular meeting of the Board of Directors (*Government Code Section 54954.2*).

Executed at Banning, California, on May 1, 2020

Bobbi Duffy

Bobbi Duffy, Executive Assistant

TAB A



COVID-19

Karan Pratap Singh, MD, MBA, FAAEM
Chief Quality Officer

SARS-CoV-2

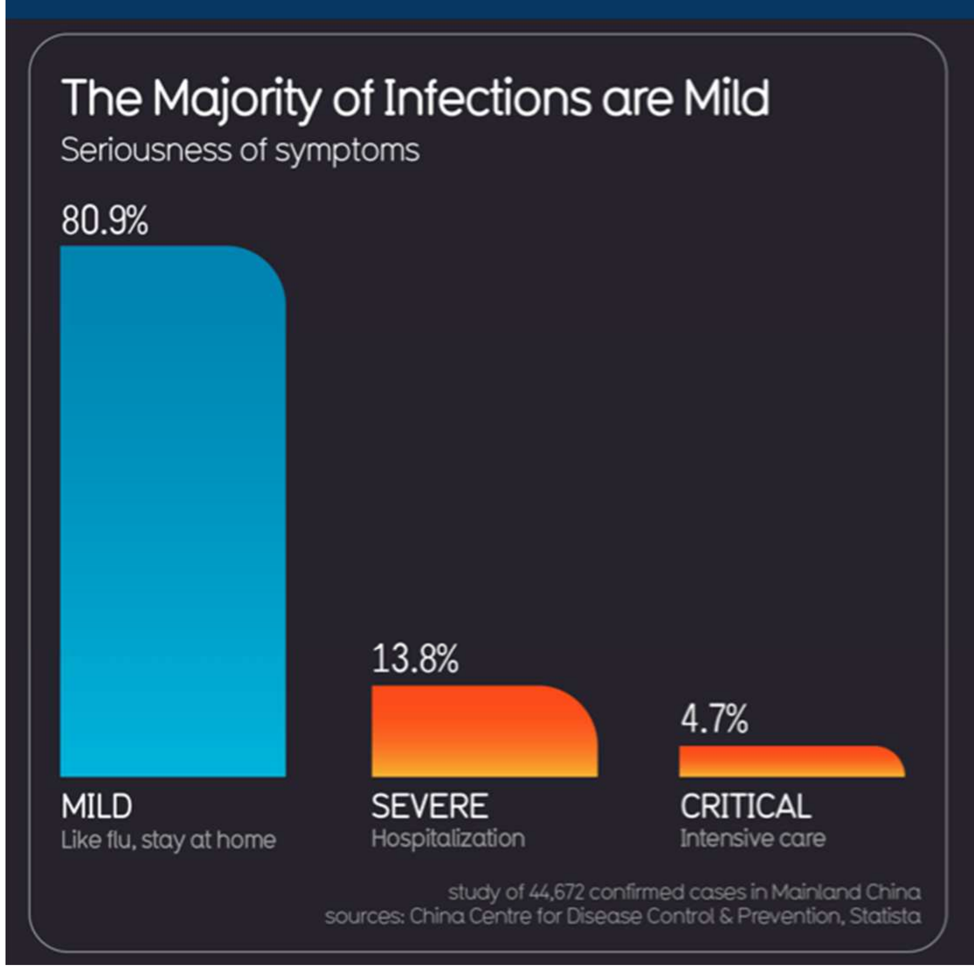
- A mutated animal virus strain that developed the ability to infect humans
- Belongs to the family of Corona viruses
    - Which are responsible for the “common cold"
- Previous novel corona viruses include SARS and MERS

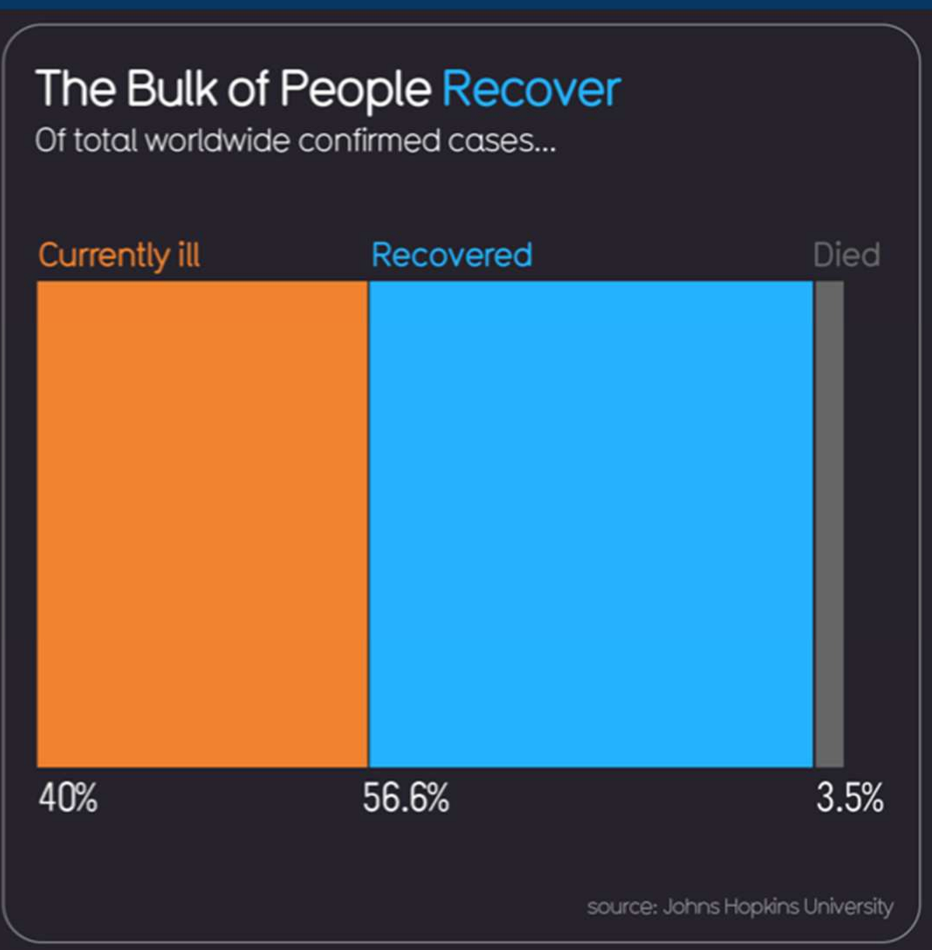
COVID-19

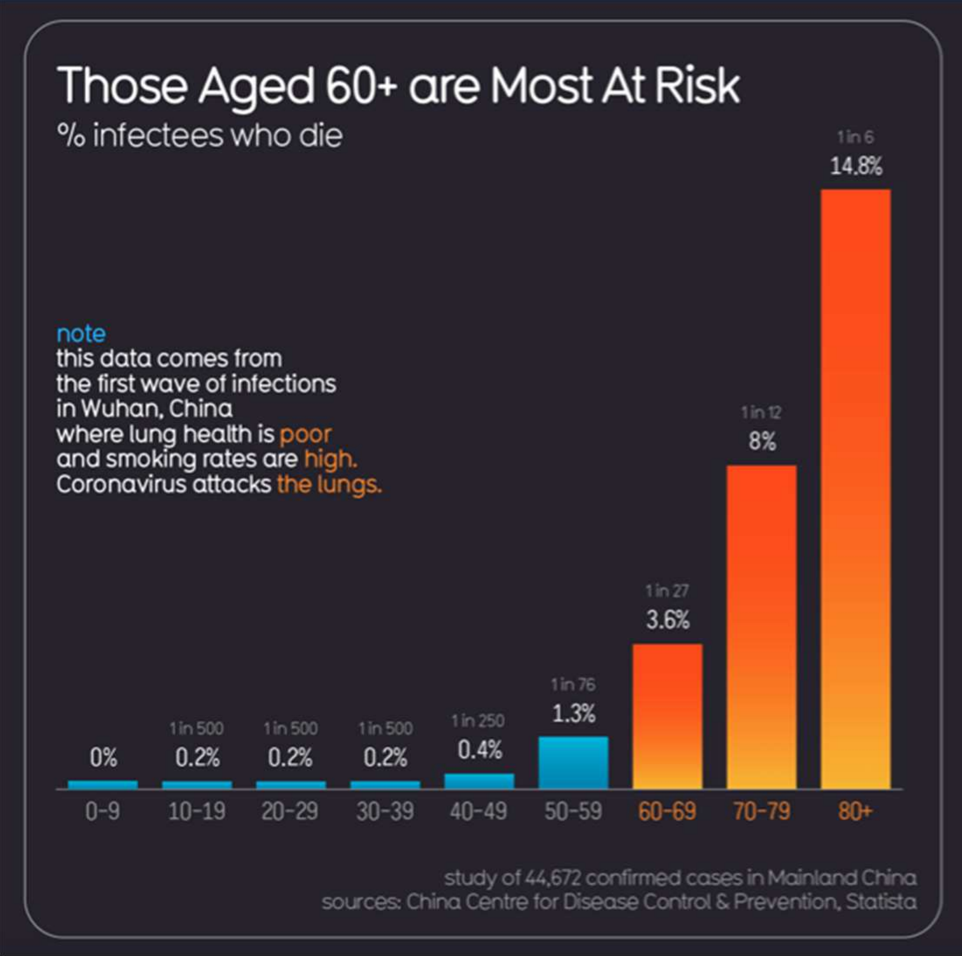
- The name for the clinical disease that occurs in humans
- Characterized by fever and cough, later shortness of breath
    - Less reliable:
        - Headache
        - Myalgias
        - Nausea
        - Diarrhea
- Symptomatic disease course is roughly 3 weeks

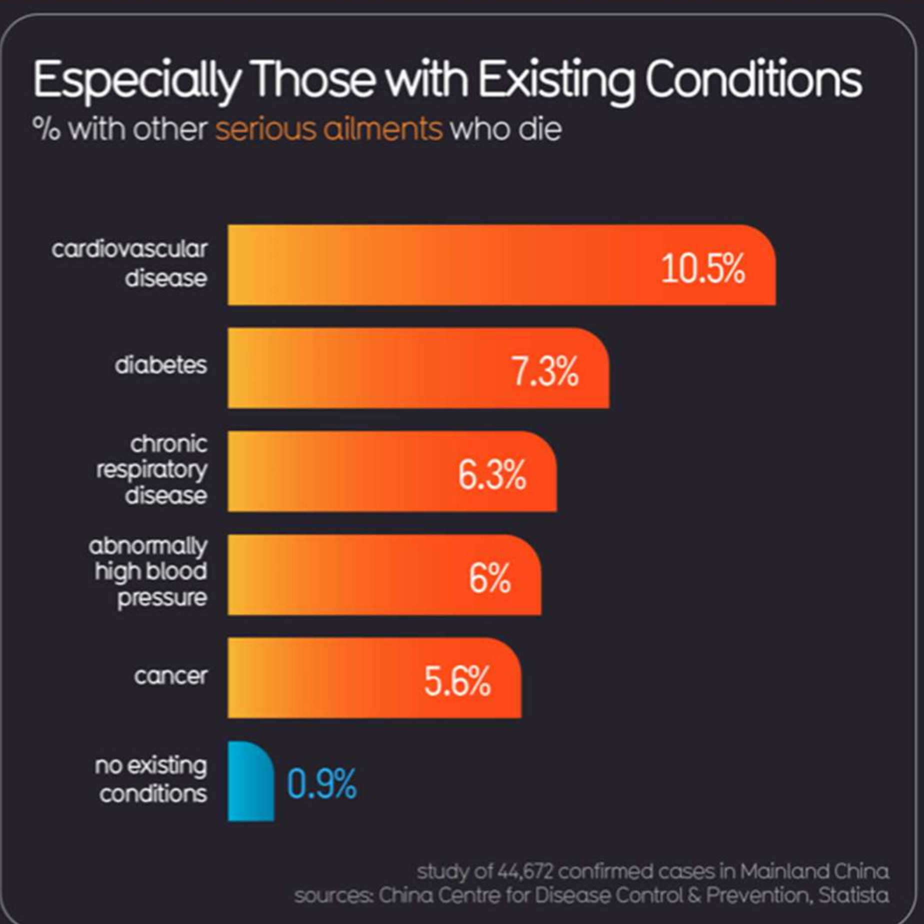
Transmission

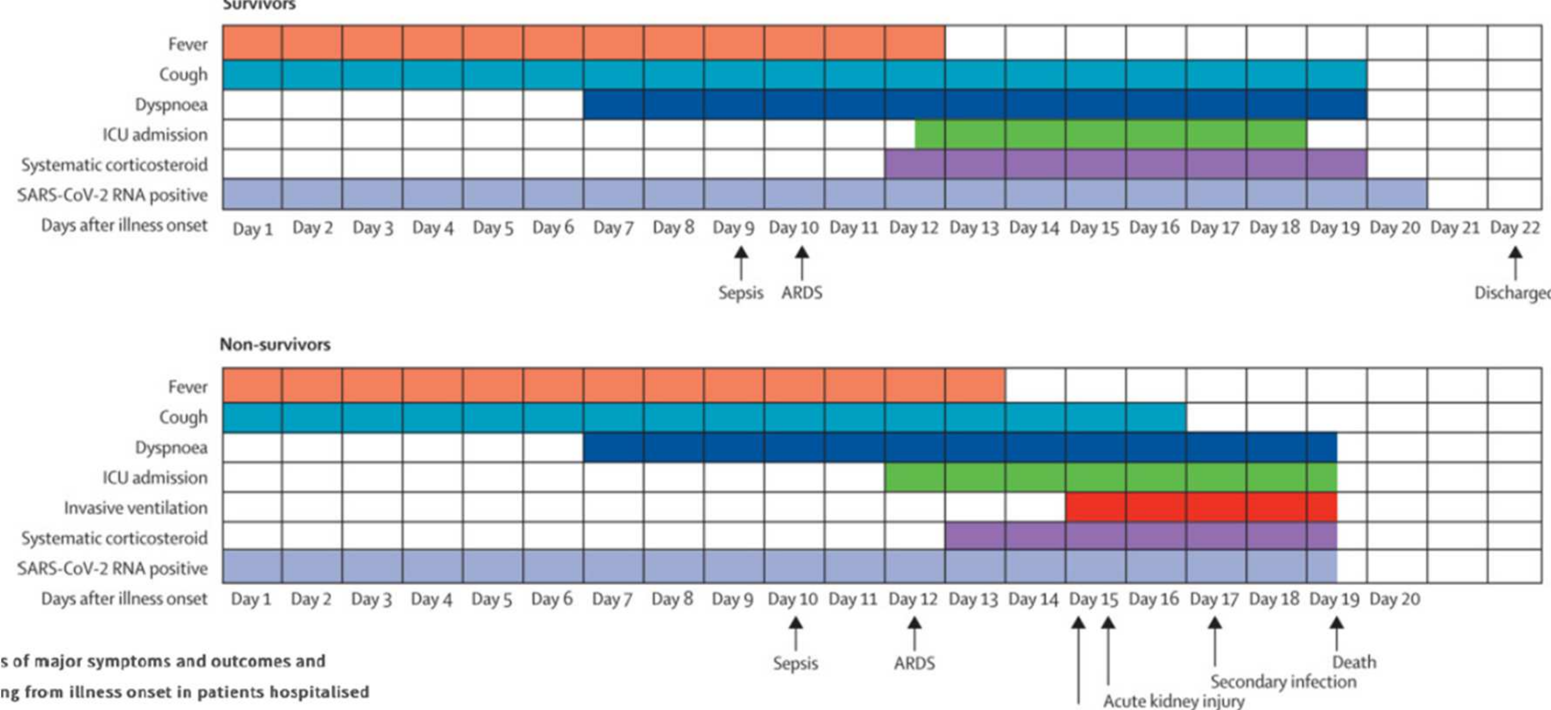
- Transmission occurs primarily over the first 8 days of illness
- Asymptomatic transmission appears to be possible
- Modes of potential transmission:
    - Droplets
    - Aerosols
    - Surfaces


The Majority of Infections are Mild
Seriousness of symptoms
80.9%
13.8%
4.7%
MILD
Like flu, stay at home
SEVERE
Hospitalization
CRITICAL
Intensive care
study of 44,672 confirmed cases in Mainland China
sources: China Centre for Disease Control & Prevention, Statista


The Bulk of People Recover
Of total worldwide confirmed cases...
Currently ill
Recovered
Died
40%
56.6%
3.5%
source: Johns Hopkins University


Those Aged 60+ are Most At Risk
% infectees who die
note
this data comes from
the first wave of infections
in Wuhan, China
where lung health is poor
and smoking rates are high.
Coronavirus attacks the lungs.
0%
1 in 500
0.2%
1 in 500
0.2%
1 in 500
0.2%
1 in 250
0.4%
1 in 76
1.3%
1 in 27
3.6%
1 in 12
8%
1 in 6
14.8%
0-9
10-19
20-29
30-39
40-49
50-59
60-69
70-79
80+
study of 44,672 confirmed cases in Mainland China
sources: China Centre for Disease Control & Prevention, Statista


Especially Those with Existing Conditions
% with other serious ailments who die
cardiovascular disease
10.5%
diabetes
7.3%
chronic respiratory disease
6.3%
abnormally high blood pressure
6%
cancer
5.6%
no existing conditions
0.9%
study of 44,672 confirmed cases in Mainland China
sources: China Centre for Disease Control & Prevention, Statista



s of major symptoms and outcomes and
ng from illness onset in patients hospitalised

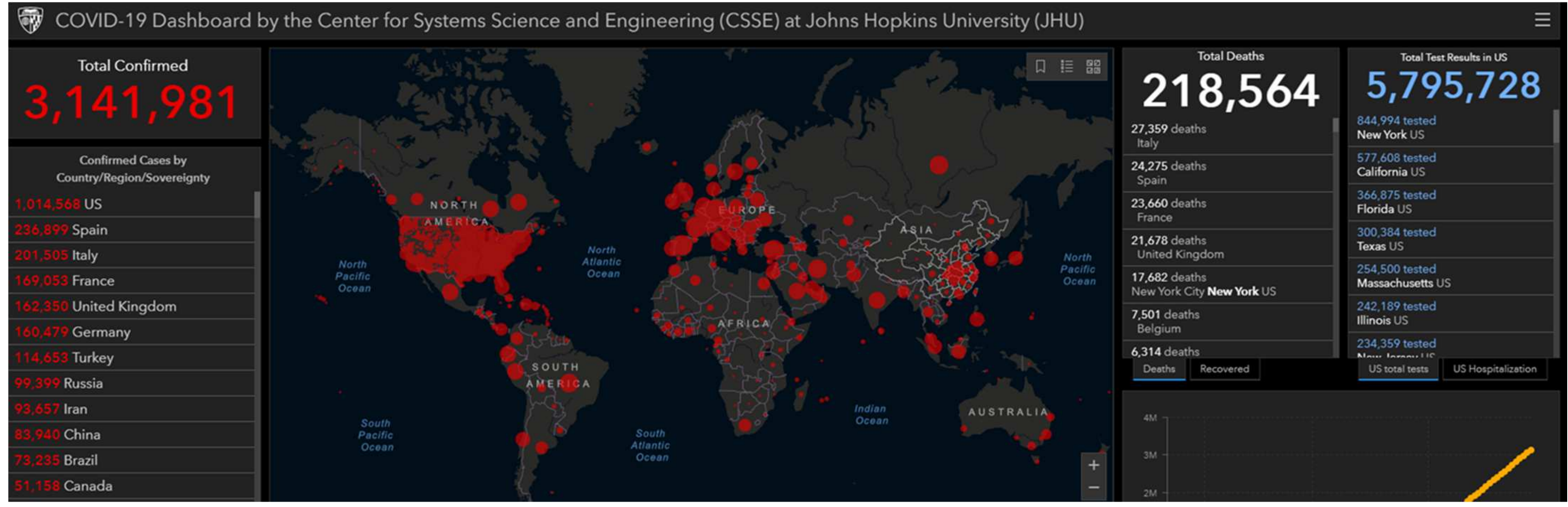
COVID progression

- Difficulty breathing occurs on average at **Day 5** from initial onset of symptoms
  - Decompensation may progress rapidly after onset of respiratory distress.

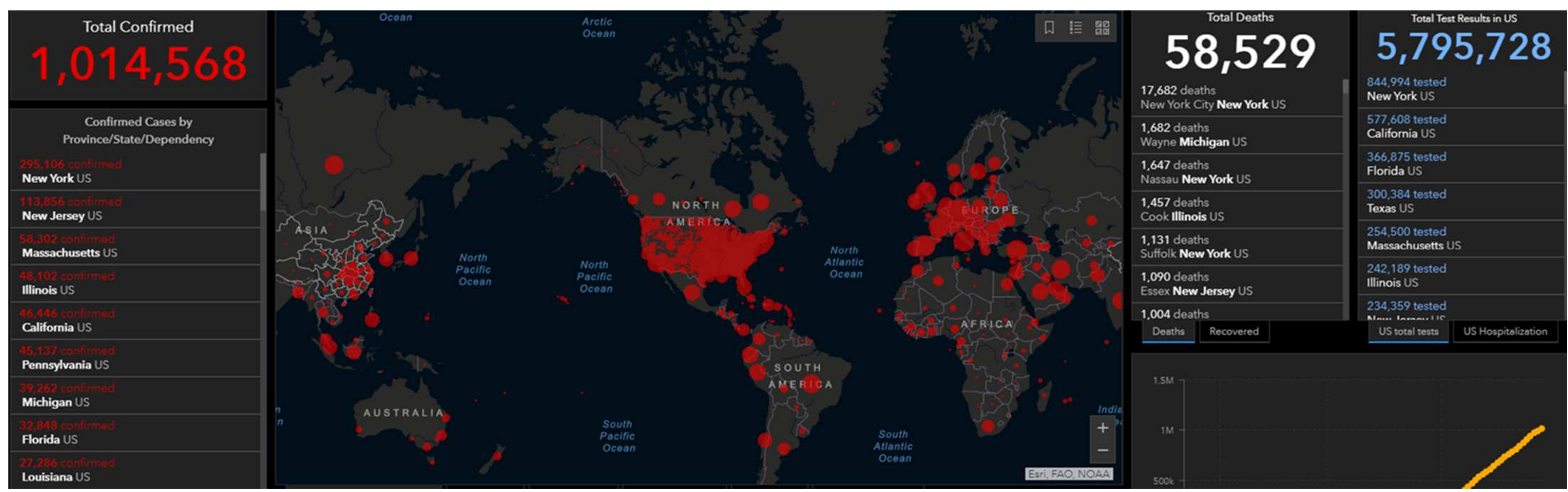
Pediatrics – Study of ~2000 patients in China

- >90% asymptomatic / mild severity
- Infants under 1 year of age most vulnerable

Global Cases – 4/29/2020



Cases in the US-4/29/2020



California COVID-19 By The Numbers

April 28, 2020

Numbers as of April 27, 2020

CALIFORNIA COVID-19 SPREAD

45,031

Total Cases

Ages of Confirmed Cases

- 0-17: 1,190
- 18-49: 21,888
- 50-64: 11,781
- 65+: 10,086
- Unknown/Missing: 86

Gender of Confirmed Cases

- Female: 22,384
- Male: 22,337
- Unknown/Missing: 310

Hospitalizations

Confirmed COVID-19

3,455/1,181

Hospitalized/in ICU

Suspected COVID-19

1,528/304

Hospitalized/in ICU

1,809

Fatalities

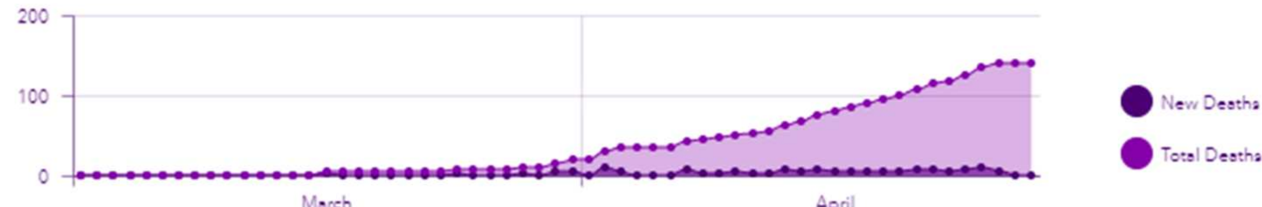
For county-level data:
data.chhs.ca.gov

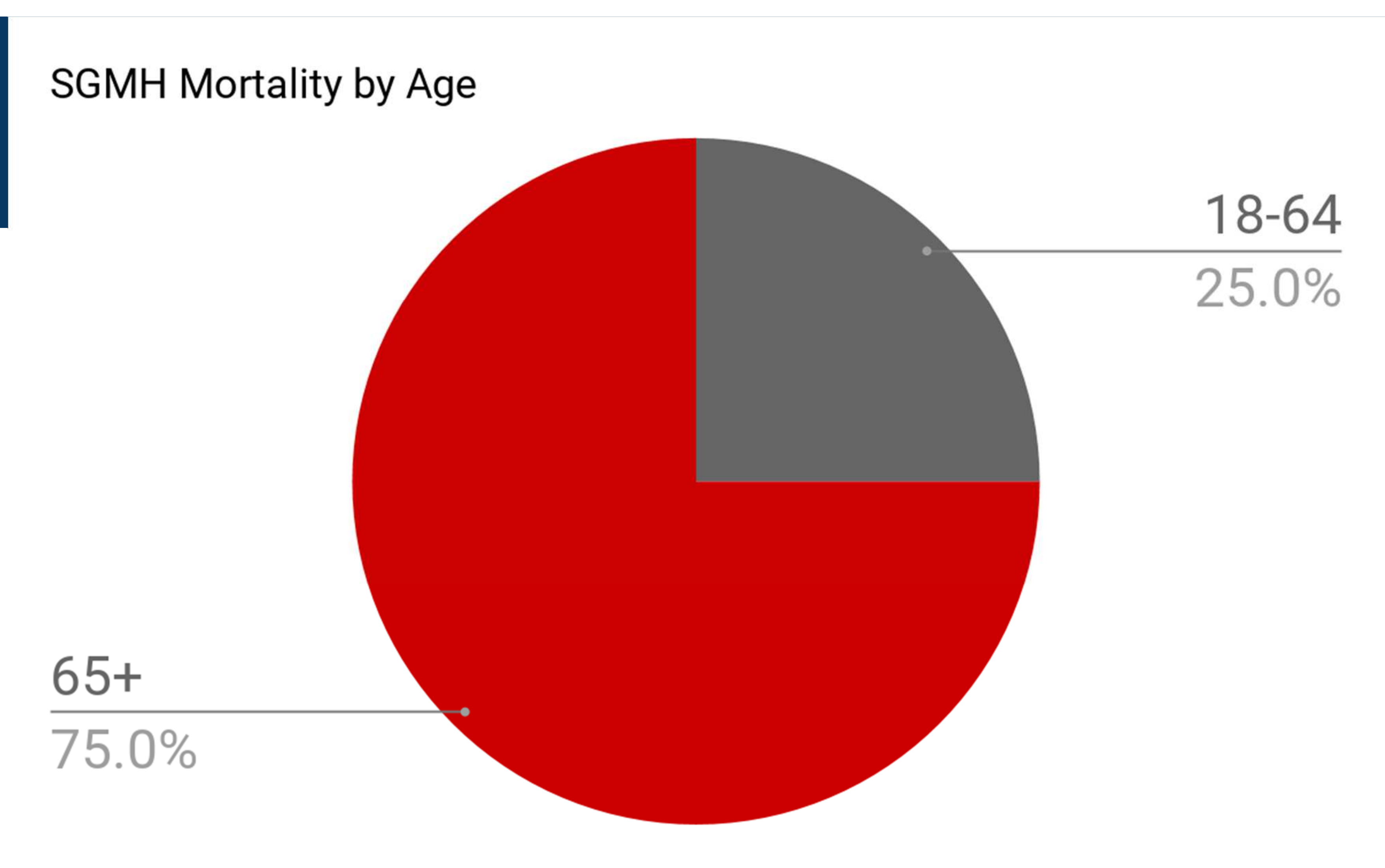
Stay Home. Save Lives.

covid19.ca.gov

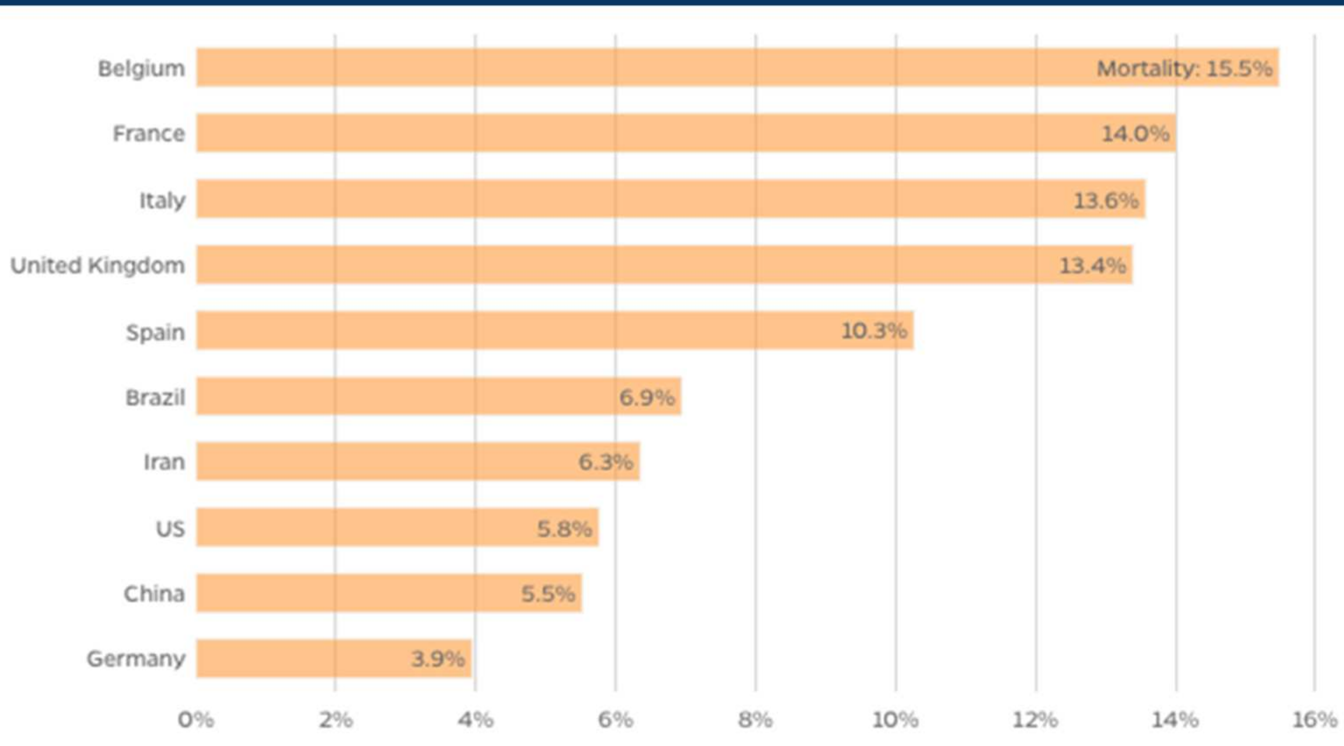
Riverside County COVID-19 Cases

Tested	Confirmed	Currently Hospitalized	Deaths	Recovered
45,417	3,735	220 Includes 73 in ICU	141	1,303




SGMH Mortality by Age
18-64
25.0%
65+
75.0%

Case-Mortality by Country



Preventing Community Exposure

- Diligent hand washing, particularly after touching surfaces in public.
- Respiratory hygiene (eg, covering the cough or sneeze).
- Avoiding touching the face (in particular eyes, nose, and mouth).
- Avoiding crowds (particularly in poorly ventilated spaces) if possible and avoiding close contact with ill individuals.
- Cleaning and disinfecting objects and surfaces that are frequently touched.

SGMH COVID Task Force

Clinical task force comprising of medical staff leadership, nurse directors, executive team, front-line staff

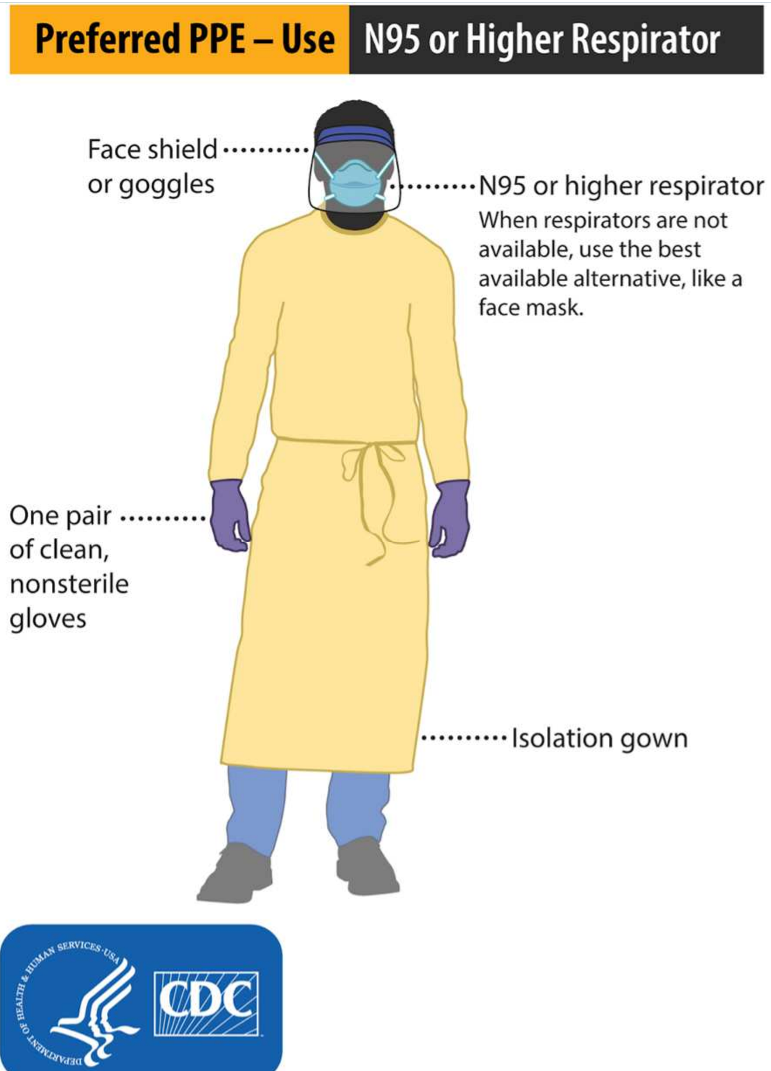
Weekly meetings to discuss changes to current patient treatment plans, patient safety discussions, best practices adoption

Daily communication with front line staff

Robust airway management and medical treatment algorithm supported by evidence based medicine

Development of educational videos, lectures and workshops by our SGMH clinical team

Safety is our priority



COVID Tent is located directly in front of the ER

Goal of our tent is to isolate potentially infected patients from the non-infected patients, in an effort to minimize spread of virus and exposure to our patients and staff

Patients with symptoms concerning for COVID are triaged by a nurse in the tent and evaluated by a clinician. Team in the tent is in full protective gear.

Patients in the tent are placed in chairs 6 feet apart from each other

Patients are provided a surgical mask to wear as they check-in

Tent Process

Patients presenting with viral symptoms that appear well clinically and have stable vitals are evaluated in the tent. They are given supportive treatment and instructed to self quarantine with instructions directly from CDC

Patients with symptoms concerning for COVID that need diagnostic testing and/or medical treatment are brought immediately to the emergency department through our ambulance doors and placed into a private, closed, negative pressure room

We bring them through the ambulance entrance in an effort to minimize exposure to other patients that may be in our lobby

Negative Pressure Rooms

Prior to COVID, STANDARD across the US to have few negative pressure rooms for **very small** subset of patients (i.e. T.B.)

Our capacity prior to COVID:
ED: 2 rooms, ICU 3 rooms

Now:

ED: **7,** ICU: **16**

We have successfully increased our negative pressure room capacity by **360%**

Negative pressure rooms help prevent airborne diseases from escaping the room and infecting other people

Inpatient

Dedicated “COVID Unit” in an effort to limit spread of virus and protect non-infected patients that are already admitted to the hospital

- Also minimizes staff exposure

Huge effort from leadership for this commitment and planning

Testing

Following CDC priority testing guidelines, admitted patients are being tested, currently swabs are sent to Quest

Average turnaround time ~ 1- 2 days

Working very hard to obtain in-house testing in the near future

RIVERSIDE COUNTY COVID-19 DRIVE THRU TESTING PROGRAM

INFORMATION AND APPOINTMENTS – 800-945-6171, 730 AM -1000 PM, 7 DAYS A WEEK

LOCATION	*ADDRESS*	*APPOINTMENTS*	*CURRENT HOURS—BUT MAY VARY*	*DAYS OPEN*	COMMENTS
RIVERSIDE	HARVEST CHRISTIAN FELLOWSHIP 6115 ARLINGTON AVENUE RIVERSIDE, CA 92504	SAME OR NEXT DAY	8-2 PM	TUES-SAT SUN/MON CLOSED	
INDIO	INDIO FAIRGROUNDS 82-503 HIGHWAY 111 INDIO, CA 92201	2-3 DAYS AHEAD	630-12 PM	TUES-SAT SUN/MON CLOSED	
PERRIS	PERRIS FAIRGROUNDS 18700 LAKE DRIVE PERRIS, CA 92571	2-3 DAYS AHEAD	8-2 PM	TUES-SAT SUN/MON CLOSED	
LAKE ELSINORE	STORM STADIUM 500 DIAMOND DRIVE LAKE ELSINORE, CA 92530	SAME OR NEXT DAY	8-2 PM	TUES-SAT SUN/MON CLOSED	YOU MAY ALSO SCHEDULE APPTS BY VISITING WWW.PROJECT BASELINE.COM/COVID19

- ✓ ANYONE WITH OR WITHOUT SYMPTOMS CAN SCHEDULE AN APPOINTMENT, WITH OR WITHOUT A PRESCRIPTION
- ✓ AVERAGE TURN AROUND TIME IS 5 DAYS—PHYSICIAN WILL CALL THE PATIENT WITH RESULTS, THIS MAY TAKE THE LONGEST*IF THE PATIENT CREATES AN ACCOUNT WITH LABCORP.COM, THE RESULTS CAN BE QUERIED SOONER VIA LABCORP ACCOUNT
- ✓ RESULTS CAN BE ENTERED INTO MYCHART.COM IF THE PATIENT HAS ESTABLISHED THIS ACCOUNT
- ✓ THE TEST IS FREE, BUT IF THE PATIENT HAS HEALTH INSURANCE, RIVERSIDE COUNTY STAFF MAY ASK FOR INSURANCE INFORMATION

Hospital Policy Changes

All associates are required to wear a hospital issued procedure mask

N95 masks to be work when providing direct patient care to patients under investigation for COVID

No more visitors in the hospital aside from few exceptions (OB, compassionate reasons, etc)

Telemedicine Monitor

We are very fortunate to have the ability to utilize telemedicine

This allows us to minimize exposure to our front line staff and also conserve our personal protective equipment supply

Planning for a potential influx of lots of patients

Cross training education for physicians, advanced practice practitioners, nurses

Telemedicine utilization

Team Nursing and Doctoring

Utilize non-clinical staff

Activate “travel” physician team to come help the hospital

TAB B

MINUTES: Not Yet Approved
By Board

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

April 7, 2020

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors was held on Tuesday, April 7, 2020. In an effort to prevent the spread of COVID-19 (coronavirus), and in accordance with the Governor's Executive Order N-29-20, there was no public location for attending this board meeting in person. Board members and members of the public participated telephonically.

Members Present: Lynn Baldi, Phillip Capobianco III, Steve Cooley, Susan DiBiasi (Chair), Olivia Hershey, Estelle Lewis, Ehren Ngo, Ron Rader, Steve Rutledge, Lanny Swerdlow, Dennis Tankersley

Absent: Andrew Gardner

Required Staff: Steve Barron (CEO), Steven Hildebrand, MD (Chief of Staff), Bobbi Duffy (Executive Assistant)

AGENDA ITEM		ACTION / FOLLOW-UP
Call To Order	Chair Susan DiBiasi called the meeting to order at 4:35 pm.	
Public Comment	Members of the public who wished to comment on any item on the agenda were encouraged to submit comments by emailing publiccomment@sgmh.org prior to this meeting. No public comment emails were received.	
OLD BUSINESS		
Proposed Action - Approve Minutes **March 3, 2020 regular meeting**	Chair DiBiasi asked for any changes or corrections to the minutes of the March 3, 2020 regular meeting as included on the board tablets. There were none.	**The minutes of the March 3, 2020 regular meeting will stand correct as presented.**
NEW BUSINESS		

AGENDA ITEM		ACTION / FOLLOW-UP
Healthcare District Board report - informational	Healthcare District Board Chair Dennis Tankersley, reported that a copy of the Healthcare District's meeting agenda and enclosures were included on the board tablets. He reviewed the actions taken at that meeting.	
Hospital Board Chair report	Chair DiBiasi noted that her written monthly report was included on the board tablets. In addition, efforts continue to work on the lease and future change over.	
Calendars	Calendars for April, May, and June were included on the board tablets.	
CEO Monthly report	Steve Barron discussed the COVID-19 pandemic. He stated that county information was current as of 1:00 pm this afternoon. He discussed the difficulty in securing PPE as we get busier and we are preparing for a possible future surge of patients. He discussed how we are accepting and screening potential ER patients in a tent located outside the ER entrance. Steve reported that all hospitals have cancelled elective procedures that we're all dependent on for revenue and that we are all hurting with revenues being so far down. Steve reported that the Hospital Association is working with insurance companies to make periodic payment reimbursements by making estimates and providing us with payments up front to assist us with cash flow. We have also applied for the same with Medicare, which would help with the immediate cash flow, but would need to be repaid in 4-6 months. Steve reported that IEHP is advancing the IGT funds payment to us. He stated that there is no guarantee that we will get any FEMA reimbursement for our additional expenses but we are keeping track of them in the event we might. Steve reported that we have set up a "COVID-19" donation fund through the Foundation and he encourages everyone to donate to it as they can. Donors should contact the Foundation Director, Valerie Hunter.	

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td>Proposed Action – Approve Resolution #2020-01</td><td>Susan DiBiasi reported that Resolution #2020-01 is a resolution of the Board of Directors of the San Gorgonio Memorial Hospital Declaring a Local Emergency.

BOARD MEMBER ROLL CALL:
<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
<tr><td>Cooley</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr>
<tr><td>Gardner</td><td>Absent</td><td>Hershey</td><td>Yes</td></tr>
<tr><td>Lewis</td><td>Yes</td><td>Ngo</td><td>Yes</td></tr>
<tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr>
<tr><td>Swerdlow</td><td>Yes</td><td>Tankersley</td><td>Yes</td></tr>
</table>Motion carried.</td><td>M.S.C., (Rader/ Hershey), the SGMH Board of Directors approved Resolution #2020-01 as submitted.</td></tr>
<tr><td>Proposed Action – Approve Resolution 2020-02</td><td>Steve Barron reported that Resolution #2020-02 is a resolution Mr. Joey Hunter or Mr. Frank Ussery to execute for and on behalf of the Hospital for the purpose of obtaining state Financial assistance provided by the State of California for the Grant Award: FY2019 California State Nonprofit Security Grant Program. He added that this is for the security cameras that Security Director Joey Hunter mentioned at a recent previous board meeting.

BOARD MEMBER ROLL CALL:
<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
<tr><td>Cooley</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr>
<tr><td>Gardner</td><td>Absent</td><td>Hershey</td><td>Yes</td></tr>
<tr><td>Lewis</td><td>Yes</td><td>Ngo</td><td>Yes</td></tr>
<tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr>
<tr><td>Swerdlow</td><td>Yes</td><td>Tankersley</td><td>Yes</td></tr>
</table>Motion carried.</td><td>M.S.C., (Rader, Cooley) SGMH Board of Directors approved Resolution #2020-02 as submitted.</td></tr>
<tr><td>Bi-monthly Business Development/Information Technology report</td><td>Steve Barron noted that the written report was included on the board tablets.</td><td></td></tr>
</table>

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Foundation monthly report</td><td>Steve Barron noted that the written report was included on the board tablets.</td><td></td></tr>
<tr><td colspan="3">COMMITTEE REPORTS:</td></tr>
<tr><td>Finance Committee

Proposed Action – Approve February 2020 Financial Statement</td><td>It was noted that due to the quarantine meeting restrictions in place, there was no March Finance Committee meeting held. The February Finance statement is being brought directly to the full board for approval.

BOARD MEMBER ROLL CALL:
<table><tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr><tr><td>Cooley</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr><tr><td>Gardner</td><td>Absent</td><td>Hershey</td><td>Yes</td></tr><tr><td>Lewis</td><td>Yes</td><td>Ngo</td><td>Yes</td></tr><tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr><tr><td>Swerdlow</td><td>Yes</td><td>Tankersley</td><td>Yes</td></tr></table>Motion carried.</td><td>M.S.C., (Hershey/ Rader), the SGMH Board of Directors approved the February 2020 Financial report as presented.</td></tr>
<tr><td>Community Benefit events/Announcements/and newspaper articles</td><td>Miscellaneous information was included on the board tablets.</td><td></td></tr>
<tr><td>Adjourn to Closed Session</td><td>Chair DiBiasi reported the items to be reviewed and discussed and/or acted upon during Closed Session will be:

➢ Proposed Action - Approve Medical Staff Credentialing

The meeting adjourned to Closed Session at 5:40 pm.</td><td></td></tr>
<tr><td>Reconvene to Open Session</td><td>The meeting reconvened to Open Session at 5:52 pm.

At the request of Chair DiBiasi, Bobbi Duffy reported on the actions taken/information received during the Closed Session as follows:

➢ Approved Medical Staff Credentialing</td><td></td></tr>
</table>

AGENDA ITEM		ACTION / FOLLOW-UP
Future Agenda Items	None at this time.	
Adjourn	The meeting was adjourned at 5:55 pm.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Respectfully submitted by Bobbi Duffy, Executive Assistant

TAB C

COVID-19 ALTERNATE BOARD PROCESSES

Press Interactions

- All questions from the press must be referred to Steve Barron, CEO.

Meeting processes

- Due to COVID-19 quarantine restrictions, meetings are being held electronically whether that means telephonically, via Webex, Zoom, etc.
- Call in numbers and access codes are provided at the top of the agendas.
- Meetings will be conducted in the regular methods lead by the respective Board Chair.

Tablet pickup and return

- PICKUP OF TABLETS
    - Once meeting materials are loaded on the tablets, they are disinfected and placed in a sealed bag.
    - Board members are notified that tablets are ready for pick up during normal business hours. Board members should NOT come into the hospital. They should notify Bobbi or Ariel when they are on their way to the hospital and then again when they are parked out front of the hospital. They should remain in their vehicle and the sealed tablet will be brought out to them.

- RETURN OF TABLETS
    - After the meeting and during normal business hours, Board members should notify Bobbi or Ariel when they are on their way to the hospital and then again when they are parked out front of the hospital. They should remain in their vehicle and we will come out to retrieve their tablet from them.
    - The tablets are disinfected and re-charged to be ready for the next use.

CONTACT:	Bobbi	desk (951) 769-2160	OR	cell (951) 663-7781
	Ariel	desk (951) 769-2101		

TAB D

Report from Chair Susan DiBiasi
May 5, 2020

April has impacted each of us and our families in ways that are different and the same. Sheltering in place and social distancing has been an interesting experiment and the outcomes and impacts are yet to be determined. The Hospital has been coordinating with Riverside County, State officials and various federal agencies to understand new requirements, flexibility in some regulations and changing information practically on an hourly basis. KUDOs to Steve Barron and the Executive Team of Pat Brown R.N., Annah Karam, Dave Recupero, Holly Yonemoto, and Dr. Karan Singh for being EXCELLENT. Our staff of clinical and support staff truly are heroes.

Thank you for all you do and are.

TAB E

May 2020

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5 **4:00 pm Healthcare District Board mtg** **4:30 pm Hospital Board mtg**	6	7	8	9
10	11	12	13	14	15	16
17	18	19 **9:00 am Community Planning Committee mtg.**	20 **9:00 am HR Committee mtg.** **5:00 Measure D Comm. Oversight** **5:15 Measure A Comm. Oversight**	21	22	23
24 / 31	25 Memorial Day Holiday Admin. Closed	26 **9:00 am Finance Committee mtg.**	27	28	29	30

As of April 30, 2020 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

June 2020

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2 **4:00 pm Healthcare District Board** **5:00 pm Hospital Board**	3	4 3:00 pm—Cafeteria General Staff mtg and Associate of the Month	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30 **9:00 am Finance Committee** **10:00 am Executive Committee**				

As of April 30, 2020 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

July 2020

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4 Independence Day
5	6	7 **4:00 pm Healthcare Dist. Board mtg.** **5:00 pm Hospital Board mtg.**	8	9 3:00 pm—Cafeteria General Staff mtg and Associate of the Month	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28 **9:00 am Finance Committee**	29	30	31	

As of April 30, 2020 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

TAB F

BMG DRAFT 03/26/20

MEDICAL GROUP PROFESSIONAL COVERAGE AND MEDICAL DIRECTOR AGREEMENT

by and between

SAN GORGONIO MEMORIAL HOSPITAL

and

BEAVER MEDICAL GROUP, L.P.

MEDICAL GROUP PROFESSIONAL COVERAGE AND MEDICAL DIRECTOR AGREEMENT

THIS MEDICAL GROUP PROFESSIONAL COVERAGE AND MEDICAL DIRECTOR AGREEMENT ("Agreement") is made effective as of **_______________**, 2020 ("Effective Date"), by and between San Gorgonio Memorial Hospital, a California nonprofit public benefit corporation ("Hospital"), and Beaver Medical Group, L.P., a California limited partnership ("Group").

R E C I T A L S

A. Hospital is the owner and operator of a general acute care hospital located at 660 N. Highland Springs Ave, Banning, California 92220, which provides hospital services including an anesthesia service that provides services to inpatients and outpatients of the Hospital ("Anesthesia Service"). Hospital does not provide physician professional medical services with respect to its Anesthesia Service.

B. San Gorgonio Memorial Health Care District ("District"): (i) is a local healthcare district that is a political subdivision of the state of California organized pursuant to the Local Health Care District Law set forth in the California Health and Safety Code ("District Law"), and (ii) owns the hospital land, building and equipment, and leases these assets to the Hospital to provide healthcare services to communities located in the District.

C. Group is a California medical professional corporation whose shareholder(s), partners, member(s), employee(s) and contracting physician(s) (each a "Physician" and collectively, "Physicians") are duly qualified and licensed to practice medicine in the State of California, including, those who specialize in providing professional anesthesia services ("Specialty"). Group and Physicians do not provide hospital services.

D. After consideration of various factors, including, the shortage of Specialty providers in the District, the need to ensure adequate physician coverage for the Anesthesia Service to serve the communities located in the District, and the quality of services provided by Group, Hospital has requested Group to be the exclusive provider of professional and administrative services to the Anesthesia Service based on a determination that this proposed arrangement with Group will enhance the delivery of Specialty Services (defined below), and improve Hospital's organization, procedure standardization, economic efficiency, and professional proficiency regarding the operation of the Anesthesia Service and the delivery of Specialty Services, and provide other benefits to enhance coordination and cooperation among providers who provide services at Hospital.

E. Hospital desires to engage Group to perform, and furnish Physicians who will perform, Specialty Services, Administrative Services and Billing and Collection Services (as those terms are defined below), and Group desires to perform, and furnish Physicians who will perform, Specialty Services, Administrative Services and Billing and Collection Services.

A G R E E M E N T

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

1. DUTIES AND OBLIGATIONS OF GROUP

1.1 Interim Specialty Services.

1.1.1 Except as set forth in Section 1.1.2 below, during the period from and after the Effective Date until October 31, 2020 or such other date as mutually agreed upon by the Parties ("Interim Period"), Hospital will be solely responsible for arranging for the provision of, or the staffing of physicians and other allied health professionals to provide professional services required by the Anesthesia Service during the Interim Period.

1.1.2 Group shall provide such Specialty Services (as defined below) required by the Anesthesia Service on a basis consistent with the then-current availability of Physicians to provide Specialty Services, as determined by Group in its reasonable discretion and consistent with Hospital's needs. Physicians shall be provided by Group and at times subject to Hospital's prior approval which shall not be unreasonably withheld. Group and Hospital shall cooperate in the scheduling of any of Group's Physicians performing Specialty Services at Hospital and in a manner that is coordinated with Hospital's arrangement of contracting or locums tenens physicians to provide professional services at Hospital. All Physicians providing Specialty Services through Group during the Interim Period shall meet the requirements set forth in Section 1.2 below and as may otherwise be required of Physicians under the Agreement, except as otherwise mutually agreed upon by Hospital and Group.

1.1.3 Group and Hospital shall be compensated for any Specialty Services during the Interim Period consistent with the terms of Exhibit E hereto. Group shall be solely responsible for billing and collecting for any Specialty Services provided by Group's Physicians during the Interim Period.

1.1.4 To the extent that Hospital has been contracted to bill for professional services in the Anesthesia Services by physicians who are not affiliated with Group, Hospital hereby designates Group during the Interim Period as its exclusive billing and collection agent with respect to all Specialty Services provided by such physician during the Interim Period. The billing and collection services provided by Group during the Interim Period shall be provided in accordance with the following terms and conditions:

1.1.4.1 Designation as Billing Agent. Hospital acknowledges and agrees, and shall require and use all reasonable efforts to ensure that any of its physician contractors providing professional services through the Anesthesia Services to acknowledge and agree, to designate Group as its exclusive power of attorney and exclusive and lawful agent and attorney-in-fact with respect to billing and collecting for Specialty Services provided through the Anesthesia Service during the Interim Period.

1.1.4.2 Process; Information. Such professional services shall be billed in the name of Hospital's contracting professional services providers, as applicable and at all times only in accordance with applicable laws, rules and regulations, and the requirements of Third Party Payors. Group shall not bill for hospital or facility services, which shall be the sole responsibility of Hospital. Hospital shall coordinate and cooperate, and shall require and use all reasonable efforts to ensure that any of its contractors providing professional services hereunder, coordinate and cooperate, with Group relating to the provision of any and all information required by Group to bill for such professional services in accordance with terms and conditions set forth under applicable arrangements of Hospital with Third-Party Payors, and underlying provider numbers, certifications, enrollment and other authorizations government, commercial and other third party payors (such agreements and authorizations with and from Third-Party Payors are hereinafter referred to individually as "Provider Authorization" and collectively, "Provider Authorizations").

1.1.4.3 All billing and collection services performed by Group for its Physicians and other physicians contracted by Hospital ("Billing and Collection Services") shall include any and all actions necessary to collect for professional services provided through the Anesthesia Service during the Interim Period, including, the following:

(1) To submit bills for any and all professional services to patients and with third-party payors, including, health plans, insurers, preferred provider organizations, employers and any other payors or responsible parties (collectively, "Third-Party Payors");

(2) To collect any and all amounts owing for professional services from any patients or Third-Party Payors, including, co-payments, co-insurance and deductibles, and to administer the deposit of all collected amounts into bank accounts of Hospital;

(3) To make any and all demands to, settle, compromise and adjust any claims in the ordinary course of business; and

(4) To take any and all other actions reasonable and necessary to the performance of the Billing and Collection Services.

1.1.4.4 Accounting; Financial Reporting. Group shall provide Hospital with timely and regular financial reports to document the provision of Billing and Collection Services in such form and format as mutually agreed upon by the Parties in accordance with industry standards.

1.1.4.5 Further Assurances. The Hospital will require and use all reasonable efforts to ensure that its applicable contractors will provide to Group any and all such additional documents and instruments as may be requested by Group with respect to the performance of the Billing and Collection Services.

1.1.4.6 Survival. The power of attorney and appointment set forth under this Section will survive the termination of the Interim Period and/or the expiration of the

term of the Agreement to the extent necessary required for purposes of Group's performance of billing and collection services for professional services provided by Hospital contracted physicians through the Interim Period, and to the extent, if any required for Group to bill for Specialty Services following the expiration of the Interim Period as set forth in this Agreement.

1.1.4.7 Consistent with Applicable Law. Hospital and Group shall perform the services and discharge their obligations under this Section 1 only as permitted by and as is consistent with applicable law.

1.2 Specialty Services: Post Interim Period.

1.2.1 Following the expiration of the Interim Period, Group shall perform, and furnish Physicians who will perform, all of the professional coverage and professional anesthesia services, and other professional obligations required to meet Hospital's obligation to arrange for the treatment of patients 24 hours per day, 7 days per week, 365 days per year, all as set forth in, and in accordance with, **Exhibit A** ("Specialty Services"). The parties acknowledge and agree that Specialty Services shall include only the professional component, and not the institutional component, of anesthesia services provided at Hospital.

1.2.2 Following the expiration of the Interim Period ("Post-Interim Period"), Group shall be the exclusive provider of Specialty Services, except as set forth in Exhibit A. Specialty Services shall be performed by Physicians who at all times during the term and any extensions and renewals of this Agreement shall meet the qualifications, requirements, and representations and warranties of this Section 1.1.2. During the Interim Period, Group shall recruit Physicians from its existing work force and/or through the employment or engagement of additional new qualified physicians as may be necessary for Group's provision of Specialty Services to Hospital following the expiration of the Interim Period. Group agrees that each Physician will be throughout the term and any extensions and renewals hereof , including the Interim Period and Post-Interim Period: (i) be qualified and licensed to practice medicine in the State of California, (ii) hold such clinical privileges as are necessary and appropriate to perform Specialty Services, and be a member in good standing of the Active or Provisional Medical Staff of Hospital ("Medical Staff") (iii) comply with Hospital's Medical Staff Bylaws and Rules and Regulations (collectively "Medical Staff Bylaws"), (iv) comply with all applicable standards and recommendations of the major accreditation agency that may serve as Hospital's accreditation body during the term of this Agreement, (v) be certified or eligible for certification by the American Board of Anesthesiology, (vi) be in legitimate possession of all customary narcotics and controlled substances numbers and licenses as required by all federal, state and local laws and regulations, (vii) possess all permits, accreditations, and certifications required to perform Specialty Services, and (viii) be eligible to participate in Medicare, Medi-Cal and other governmental health care programs that provide coverage to Hospital's patients. Further, except as may be disclosed by Group in writing to Hospital, Group represents and warrants to Hospital that each Physician: (i) has never had Physician's license to practice medicine in any state suspended, revoked or restricted; (ii) has never been reprimanded, sanctioned or disciplined by any licensing board or medical specialty board, (iii) has never been excluded, terminated, or suspended from participation in, or sanctioned by, any state or federal health care program, including the Medicare or Medi-Cal programs, and each Physician has never owned, controlled, managed, or been affiliated with, any person or entity that has been excluded, terminated, or

suspended from any state or federal health care program, including the Medicare or Medi-Cal programs, and (iv) has never been denied membership or reappointment of membership on the medical staff of any hospital, and each Physician's medical staff membership or clinical privileges have never been suspended, restricted, or revoked for a medical disciplinary cause or reason. Each Physician providing Specialty Services must be approved in advance in writing by Hospital. Group shall notify Hospital within seven (7) business days of becoming aware that any Physician fails to meet any of the qualifications or requirements, or any of the representations and warranties, of this Agreement.

1.2.3 The Parties acknowledge and agree that following the expiration of the Interim Period, Group may from time to time also engage one (1) or more locums tenens physicians to provide the Specialty Services as a Physician under this Agreement on a temporary basis as may be required to ensure appropriate staffing as required under this Agreement. Such locum tenens physicians shall obtain temporary clinical privileges in accordance with the requirements set forth in the Hospital's Medical Staff Bylaws (as defined below).

1.3 Medical Director.

Group shall furnish [____________], M.D., to serve as Medical Director with respect to Hospital's Anesthesia Service and Specialty Services provided hereunder ("Medical Director") in accordance with the terms and conditions of this Agreement. Medical Director, at all times during the term and all extensions and renewals of this Agreement, shall meet and comply with the qualifications and requirements of Physicians under Section 1.2. Group shall provide Hospital with at least thirty (30) days' prior notice in the event that Medical Group desires to designate another Physician to (i) provide any services of the Medical Director in the absence or support of the Medical Director and/or (ii) replace the then-current Medical Director, and any such change shall be subject to Hospital's approval, not to be unreasonably withheld.

1.3.1 Administrative Services.

Medical Director shall perform any and all duties as requested by Hospital and which are required by this Agreement, including, applicable statutes, applicable regulations, applicable accreditation standards, the Hospital Bylaws, and the Hospital Medical Staff Bylaws and Rules and Regulations (collectively "Medical Staff Bylaws") for the administration of the Anesthesia Service, including, without limitation, those administrative duties and services that are specifically set forth in **Exhibit B** (collectively, "Administrative Services").

1.3.2 Administrative Hours. Medical Director shall devote as much time and attention as are necessary in performing Administrative Services to provide for the proper and adequate management of Hospital's Anesthesia Service. Hospital shall compensate Group for services provided by Medical Director at a rate of $175 per hour for a maximum of sixteen (16) hours per month, or a total maximum of $2,800 per month during the term of this Agreement. Medical Director shall set his/her own work schedule in coordination with Hospital and consistent with the proper operation of the Anesthesia Service. By the fifteenth (15th) day of each month the Medical Director shall provide Hospital with a detailed log of Medical Director's administrative hours for the preceding month, in a form as set forth in accordance with Exhibit C ("Activity Log").

1.4 Use of Premises. Group and Physicians shall not use any of the Hospital's premises, personnel, equipment, facilities, or supplies, for Group's or Physician's private practice of medicine that is unrelated to the conditions for which Group and Physicians provide professional medical services to any patient during the patient's stay at Hospital.

1.5 Group Obligations.

1.5.1 Group shall be solely responsible for the payment of all salaries, wages, bonuses, benefits, taxes, and all other withholdings and charges payable to or by, or in respect to, Group and Physicians for services provided under this Agreement and respecting all other personnel, persons, and entities employed or contracted by Group, whether or not they provide services under this Agreement.

1.5.2 Group shall be solely responsible for the satisfaction of any and all obligations it assumes with respect to any and all partners, shareholders, associates, employees, agents or contractors that it retains, employs or contracts with. Such obligations shall include, but not be limited to, payment of all federal and state withholding taxes applicable to employees, compliance with all applicable federal, state, and local employment laws and regulations, including wage-hour (including overtime), equal employment opportunity and anti-harassment requirements, workers' compensation, unemployment insurance obligations, Medicare, social security, and other applicable taxes and contributions to government-mandated employment related insurance and similar programs, if any. Group further agrees that, to the extent any federal, state or local taxing authority seeks to collect any of the above-described taxes from the Hospital as a result of the engagement set forth in this Agreement, Group shall indemnify the Hospital for any payments made by the Hospital to such authorities, whether such payments represent taxes or penalties.

1.6 Medical Records and Claims. Group shall cause a complete medical record to be timely prepared and maintained for each patient. This record shall be made on forms provided by Hospital. Group shall maintain all medical records and charts, in accordance with industry standards, and in compliance with all State and Federal laws and regulations, the regulations and requirements of the voluntary professional facility accrediting institutions in which Hospital participates, and as may be required by the Medical Staff Bylaws, and to the extent that such requirements have been disclosed in writing to Group, by Hospital's policies and procedures. Group shall maintain and provide reasonable access to all such records and charts to patients and Hospital, and to State and Federal agencies, as may be necessary for Group and/or Hospital to document Group's provision of Specialty Services and Administrative Services under this Agreement and comply with applicable State, Federal, and local laws and regulations and with contracts between Hospital and third-party payors. Group shall cooperate with Hospital in completion of such claim forms for patients as may be required by insurance carriers, health care service plans, governmental agencies, or other payors. Group shall retain its records and information for at least seven (7) years after the termination of this Agreement. Group shall cooperate with Hospital in completion of such claim forms for patients as may be required by insurance carriers, health care service plans, governmental agencies, or other payors.

1.7 Third Party Payor Arrangements. Group shall comply with the requirements and provisions set forth in **Exhibit D**.

1.8 Group Responsible for Physician and Medical Director Performance. Group shall require, and agrees, that each Physician and Medical Director will perform the duties and services, and comply with the terms and condition, of this Agreement as they apply to Group, and Physicians and Medical Director, as the case may be.

2. BILLING AND COMPENSATION

Billing and compensation for Specialty Services and Administrative Services shall be as set forth in, and made in accordance with, **Exhibit E**.

3. TERM AND TERMINATION

3.1 Term. The Agreement shall commence on __________________, 2020 ("Commencement Date"), and shall remain in effect and continue for a period of two (2) years ("Initial Term") from and after the Commencement Date. Following the Initial Term, the Agreement will automatically be renewed and extended for three (3) additional one year terms unless otherwise terminated in accordance with the provisions set forth herein. Notwithstanding the foregoing and any other provision of the Agreement, the Agreement may be terminated as set forth in Section 3.2 during the Initial Term and during any renewals or extensions of the Agreement (hereinafter, the "Term").

3.2 Termination of Agreement. This Agreement may be terminated upon any of the following:

3.2.1 Either party may terminate this Agreement at any time after the Initial Term without cause and without cost or penalty, by providing at least one hundred twenty (120) days' advance written notice to the other party,

3.2.2 Either party may terminate this Agreement at any time by providing at least thirty (30) days advance written notice to the other party if the party to whom such notice is given is in breach of any material provision of this Agreement. The party giving such notice of termination shall set forth in the notice the facts underlying its claim that the other party is in breach of this Agreement. Notwithstanding the foregoing, this Agreement shall not terminate in the event that the breaching party cures the breach, to the satisfaction of the non-breaching party, prior to the expiration of the thirty (30) day notice period.

3.2.3 Hospital may terminate this Agreement effective immediately upon written notice to Group upon the occurrence of the following:

3.2.3.1 If Hospital determines in good faith that any aspect of the performance, or past or present conduct, of or by a Physician adversely affects the life, health, or safety of any patient, Hospital personnel, Medical Staff member, or other practitioner, or will subject Hospital to ill repute, including without limitation any criminal violations, sexual or other inappropriate harassment, or moral turpitude;

3.2.3.2 If Group engages or utilizes a Physician or other person to perform Specialty Services in connection with this Agreement who is not approved by Hospital;

3.2.3.3 The insurance required of Group hereunder is cancelled or not renewed; or

3.2.3.4 If Group fails to remove or find a substitute Physician as set forth in Section 3.3 of the Agreement.

3.2.4 Fair Market Value and Commercial Reasonableness. The Parties acknowledge and agree that the compensation payable to Group under this Agreement is intended to be consistent with fair market value and commercially reasonable standards, as such terms are defined on a basis consistent with standards promulgated by the Center for Medicare and Medicaid Services. Hospital shall obtain an opinion from an independent compensation expert mutually agreed upon by the Parties that the terms and conditions set forth under this Agreement are consistent with fair market value and commercially reasonable standards, and shall provide a copy of said opinion to Group contemporaneously with receipt by Hospital. This Agreement may be terminated without cost or penalty at any time prior to the Effective Date by either Party if such Party does not receive adequate assurances, as determined in the sole discretion of either Party, that compensation and the other terms and conditions set forth in this Agreement are consistent with fair market value and commercial reasonableness standards.

3.3 Removal of Physician. Upon request by Hospital, Group shall promptly remove any Physician from providing services under this Agreement and shall assure that such Physician will not perform any Specialty Services under the Agreement, and such Physician shall remove himself or herself from so providing such services under the Agreement, in the event such Physician:

3.3.1 Engages in conduct that jeopardizes the health, safety, or welfare of any person, or the Hospital's reputation;

3.3.2 Fails to meet any of the qualifications or requirements, or representations and warranties, specified in Section 1.1;

3.3.3 Has his or her Medical Staff membership, Medical Staff clinical privileges, or license to practice medicine terminated (whether voluntarily or involuntarily), restricted or suspended;

3.3.4 Is convicted of any crime punishable as a felony;

3.3.5 Fails to meet any of the requirements or to comply with any of the terms or conditions of this Agreement after being given notice of that failure and a reasonable opportunity to comply;

3.3.6 Is excluded from participation in any state or federal health care program, including the Medicare or Medicaid programs; or

3.3.7 Is disabled for more than thirty (30) consecutive days or more than thirty (30) days in a ninety (90) day period, or dies.

In addition to removing any such Physician as required hereunder, Group shall obtain, at its sole cost and expense, a substitute Physician approved in advance in writing by Hospital.

Notwithstanding any other language set forth in this Agreement, Group shall not be required to remove any Physician from the performance of services under the terms of this Agreement to the extent that such removal conflicts with notice and hearing requirements under the Hospital's Medical Staff Bylaws, rules or regulations or applicable laws, rules or regulations. In such event, Group shall follow such notice and hearing requirements.

3.4 Effect of Termination.

3.4.1 Upon expiration or termination of this Agreement, neither party shall have any further obligation hereunder except for (i) obligations due and owing which arose prior to the date of termination, (ii) obligations, promises, or covenants contained herein which expressly extend beyond the term of this Agreement, and (iii) Group and Physicians shall continue to provide services to patients under their care at the time of expiration or termination, until the patient's course of treatment is completed or is transferred to the care of another physician(s). In the event that a Physician's Medical Staff membership or clinical privileges necessary to perform Specialty Services hereunder has been restricted, suspended, or revoked, Group and such Physician shall ensure that the care of each of Physician's patients is appropriately transferred to another physician.

3.4.2 Upon expiration or termination of this Agreement, and upon Hospital's request, Group and Physicians shall immediately vacate the Hospital premises on the effective date of the termination or expiration, removing at such time any and all of Group's personal property. Hospital may remove and store, at Group's expense, any personal property that Group has not so removed.

3.4.3 Following the expiration or termination of this Agreement, Group and Physicians shall not do anything that might interfere with any Hospital efforts to contract with any other individual or entity for the provision of Specialty Services or to interfere in any way with any relationship between Hospital and any medical group or physicians who may replace Group or may provide services for Hospital similar to those provided by Group hereunder.

3.4.4 Expiration or termination of this Agreement shall not create any independent contractual hearing, review, or appeal rights for Group or any Physician under the Medical Staff Bylaws; provided, however, that such termination may be subject to, and shall not limit, any rights to such hearing, review, appeal or other rights for Group or any Physicians that are required under Hospital's Medical Staff Bylaws, Rules and Regulations or applicable laws, rules and regulations, including, without limitation, such rights of hearing and review relating to matters involving quality of patient care or any other medical disciplinary cause or reason, or is otherwise reportable to any state's medical board or other agency responsible for professional licensing, standards or behavior.

4. INSURANCE AND INDEMNIFICATION

4.1 Group Insurance.

4.1.1 Group shall maintain at Group's sole expense, a policy or policies of professional liability insurance as required by this Section. Such insurance shall provide coverage for Group and each Physician as the named insureds, and such policy shall cover all acts and omissions of Group and Physicians and any professional negligence which may have occurred during the relevant term and said policies of insurance shall be written with limits of liability of at least the minimum coverage required from time to time by the Hospital's Medical Staff Bylaws, but in any event no less than One Million Dollars ($1,000,000) per claim/Three Million Dollars ($3,000,000) per year subject to applicable aggregates for "claims made" insurance coverage. Group further shall maintain "continuous coverage", as defined by this Section for the entire relevant term. The relevant term shall commence with the Commencement Date of this Agreement, and shall continue through the Term of this Agreement, and all extensions and renewals hereof, and for a period thereafter of no less than three (3) years. In order to maintain continuous coverage for the entire Term and extensions and renewals, Group shall, if it changes insurers for any reason, take the necessary actions required in order to provide continuous coverage by either obtaining "tail" insurance from the preceding carriers, or "nose" insurance from the subsequent carriers. In order to satisfy the requirements of this Section, the "tail" insurance must be of either an unlimited type or of the type which would extend the discovery period beyond the last effective day of the last contract between the parties for a period of three (3) years. In order to satisfy the requirements of this Section for "nose" insurance, the retroactive effective date for such insurance must be at least the first date of the relevant term noted above. Upon request of Hospital, Group will provide Hospital proof of current insurance and, in the event of modification, termination, expiration, non-renewal or cancellation of any of the aforesaid policies of insurance, Group shall give Hospital written notice thereof within five (5) business days of Group's receipt of such notification from any of its insurers. In the event Group fails to procure, maintain or pay for said insurance as required herein, Hospital shall have the right, but not be obligated to obtain such insurance. In that event, Group shall reimburse Hospital for the cost thereof and failure to repay the same upon demand by Hospital shall constitute a material breach hereunder.

4.1.2 Because Group is an independent contractor, Group agrees to maintain at Group's sole expense, a policy or policies of professional liability insurance covering Group and each Physician, for the maximum amount permitted by law, against any and all losses or expenses (including income and medical expenses) due to any illnesses, injuries or a fatality incurred or suffered by any Physician while engaged in providing any services for the Hospital.

4.1.3 Notwithstanding the foregoing, Group shall immediately notify Hospital's Risk Management Department not later than ten (10) days after receipt of any notice or communication of any kind, of any intent to commence or possibly commence, or of any actual, legal action, lawsuit, claim, incident, arbitration, mediation, or other dispute resolution proceeding of any kind, concerning any act or omission of Group or a Physician and/or any and all personnel employed or contracted by Group involving any patient treated at Hospital or involving any employee, contractor, or visitor of Hospital ("Legal Action").

4.2 Indemnification.

4.2.1 Group shall indemnify and hold harmless Hospital and its respective directors, officers, trustees, employees, successors, assigns, insurers, licensees, distributors, attorneys, and agents, from and against any and all claims, damages, judgments, liabilities, losses, deficiencies, actions, suits, judgments, interest, fines, penalties, costs, and expenses, including without limitation attorney's fees, which (i) relate to any incidents, events, acts (or failure to act) that occur from and after the date of this Agreement and arise or result from Group's and/or any Physician's performance or failure to perform in accordance with the terms set forth in this Agreement, or (ii) relate to Group's provision of Specialty Services and arise or result from any acts or omissions of Group and/or any Physician and/or any and all personnel or other persons or entities employed by Group.

4.2.2 Hospital shall indemnify and hold harmless Group and Group's Physicians and affiliates and their respective directors, officers, trustees, employees, successors, assigns, insurers, licensees, distributors, attorneys, and agents, from and against any and all claims, damages, judgments, liabilities, losses, deficiencies, actions, suits, judgments, interest, fines, penalties, costs, and expenses, including without limitation attorney's fees (i) which arise or result from Hospital's breach of any representations or warranties and/or performance or failure to perform in accordance with the terms set forth in this Agreement, or (ii) which arise or result from any acts or omissions of Hospital and/or any and all personnel or other persons or entities employed by Hospital (other than Group and Group's personnel, including without limitation the Physicians).

5. OBLIGATIONS OF HOSPITAL.

5.1 Administration of Anesthesia Service. Nothing in this Agreement shall be construed to limit the authority of Hospital to administer and operate the Anesthesia Service as required under the Hospital's licensure for hospital and supplement services. Throughout the term of this Agreement, Hospital shall ensure that the Anesthesia Service is operated throughout the term of this Agreement in accordance with (i) applicable laws, rules, regulations, (ii) requirements of third-party payors, (iii) standards imposed by accreditation, ethical bodies and industry practices, and (iv) the policies and procedures of Hospital and Medical Staff. Without limiting the generality of the foregoing, the Hospital's fulfillment of such obligations shall include without limitation, the items set forth in this Article 5.

5.2 Facilities. Hospital shall provide or arrange for the provision of the land, buildings, fixtures, furnishings, and any all services and support reasonably necessary for the Anesthesia Services.

5.3 Equipment; Information Technology. Hospital shall furnish or arrange for the provision to the Anesthesia Services of all appropriate medical equipment, instruments, medical fixtures, office equipment, furniture, fixtures, improvements, and information technology, including, without limitation, telephones, communication resources, computers, on-line computer services, digital data, communication lines, voicemail, medical records systems, practice management and other items necessary and appropriate for the operation of the

Anesthesia Service. Hospital shall maintain and timely repair, replace, and supplement such equipment as necessary and otherwise maintain it in good working order.

5.4 Supplies. Hospital shall acquire and supply or arrange for the provision to the Anesthesia Service of all medical and non-medical supplies, and appropriate utilities reasonably required in order to conduct and operate the Anesthesia Service.

5.5 Personnel. Hospital shall provide or arrange for all non-physician personnel required for the operation of the Anesthesia Service. All personnel employed or otherwise engaged by the Hospital to operate, administer or support the Anesthesia Service shall be fully trained and fully licensed by all appropriate governmental authorities to the extent required by law. Hospital shall provide Group with an opportunity to consult with Hospital on an on-going basis regarding, the performance of Anesthesia Service personnel.

5.6 Insurance. Hospital shall maintain commercially reasonable insurance coverage necessary for the operation of the Anesthesia Services and the Hospital in general in accordance with industry standards.

5.7 Representations and Warranties. As an inducement for Group to enter into this Agreement, Hospital represents and warrants that the following are true and correct as of the Effective Date and the Commencement Date and shall remain true throughout the term of this Agreement:

5.7.1 Best Interests. The Hospital's request for Group to enter into the Agreement in accordance with the terms set forth herein is based on Hospital's determination that the arrangement is necessary to further the best interests of the Hospital and the patients residing in the District, including, without limitation, based on a consideration of those certain benefits to the Hospital and the District that are identified in Recital C above, the terms of which are incorporated and made a part of this representation;

5.7.2 Due Authority; Necessary Approvals The Hospital (i) has full power and authority to enter into this Agreement and/or (ii) has obtained or will obtain prior to the Effective Date any and all necessary approvals and consents required with respect to (1) Group's right to be the exclusive provider of Specialty Services to the Anesthesia Service as set forth herein and/or (2) the other terms and conditions set forth herein, including, without limitation, any consents or approvals required by the Hospital, the District or the Medical Staff.

5.7.3 No Breach. This Agreement does not violate any obligations under any contracts or other obligations of Hospital. Any and all other agreements and rights of any person or entity relating to the subject matter of this Agreement have been terminated or voided in accordance with applicable laws, rules and regulations, and any such prior arrangements are of no further force or effect. Neither BMG nor any of its affiliated entities, including, EPIC Health Plan and EPIC Management, L.P., or any of its employees, officers, directors or agents (collectively, "BMG Affiliates") participated, influenced or otherwise were involved in the decision making process of Hospital and its affiliates to terminate any such prior agreements relating to the Anesthesia Service.

5.7.4 No Other Representations. Hospital acknowledges and agrees that Group has made no express or implied representations or warranties regarding its provision of Specialty Services under this Agreement, the operation of the Anesthesia Service or otherwise relating to the subject matter of this Agreement, except as expressly set forth in this Agreement.

6. MISCELLANEOUS

6.1 Independent Contractor. In the performance of its duties and obligations hereunder, Group is at all times acting as an independent contractor of Hospital, and not as an employee, agent or servant of the Hospital. Nothing in this Agreement shall be construed to create an employment relationship, joint venture, partnership, lease, association or other affiliation or like relationship between the parties, it being specifically agreed that the relationship is and shall remain that of independent parties to a contractual relationship as set forth in this Agreement. Group acknowledges and agrees that Group will be solely responsible for reporting and paying all taxes, interest and penalties on all payments made under this Agreement. Group understands and agrees that Group and Physicians are not entitled to any employment benefits the Hospital may provide to its employees, including without limitation, workers' compensation insurance, unemployment insurance benefits, group health insurance benefits, and pension and similar benefits. Hospital shall exercise no control or discretion over the methods by which Group and any Physician performs Specialty Services. Group shall indemnify and hold harmless Hospital from and against any and all liabilities, claims, or expenses for fees, compensation, wages, benefits, costs, expenses and taxes Hospital would incur if, contrary to the parties' intentions, Group, any Physician, and/or any and all personnel employed or contracted by Group is deemed to be an employee of the Hospital.

6.2 Confidentiality.

6.2.1 Subject to Hospital's obligations under Compliance and Related Requirements (as that term is defined in Section 6.4.1), the parties agree that the terms and conditions of this Agreement, including its financial terms, are confidential. Accordingly, each party agrees not to disclose to any other person or entity, any term or condition of this Agreement, or of any other agreement referred to in this Agreement, or of any transaction contemplated by this Agreement, except to its legal, accounting, or tax advisors, or with the prior written consent of the other party, or as may be required by law.

6.2.2 The parties acknowledge that in connection with its performance under this Agreement, each party or will have access to and the use of confidential information and trade secrets (the "Confidential Information") of the other party's operations, that is not generally known to the public, which include, but are not limited to, financial statements, internal memoranda, reports, patient lists, business plans, methods and know-how, and other materials or records of a proprietary nature. To protect the Confidential Information, each party agrees that neither it nor any of its employees or agents will, from and after the Effective Date of this Agreement and for so long as any such Confidential Information remains confidential, secret or otherwise wholly or partially protectable, including beyond the expiration or termination of the Agreement, directly or indirectly, use such information (except in connection with the performance of duties hereunder) or divulge the Confidential Information to any third party,

without first obtaining the prior written consent of the other party, which may be withheld at such party's sole discretion.

6.2.3 Any and all of the Hospital's patient records, charts, protected health information, and other patient-related information created or received as a result of either party's performance under this Agreement shall be and remain the property of Hospital; provided, however, that nothing contained herein shall limit or modify Group's right to document the nature of its Specialty Services provided hereunder in accordance with industry standards and applicable laws, rules and regulations. Both during and after the term of this Agreement, Group, or its agents, shall be permitted to inspect, duplicate, and/or obtain an electronic copy in a mutually agreed to format, at Group's expense, any individual patient chart, record or other information to the extent necessary for treatment for such patients, to meet its professional responsibilities to such patient(s) and/or to assist in the defense of any malpractice or similar claim to which such chart or record may be pertinent, provided that such inspection, duplication or receipt is permitted and conducted in accordance with the applicable legal requirements and pursuant to commonly accepted standards of patient confidentiality.

6.2.4 Notwithstanding the foregoing, Hospital, Group, Physicians, and their respective agents shall only use or disclose patient records or other records containing a person's individually identifiable information in a manner that complies with applicable federal and state requirements for the protection of the privacy and security of patient data. Such requirements include, without limitation, those set forth in: (i) the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009, and the regulations promulgated pursuant to each such Act, including 45 Code of Federal Regulations (CFR) Parts 160 and 164 (collectively, "HIPAA"); (ii) the California Confidentiality of Medical Information Act, California Civil Code Section 56 et seq.; (iii) the Lanterman-Petris-Short Act, California Welfare and Institutions Code Section 5000 et seq.; (iv) the Patient Access to Medical Records Act, California Health and Safety Code Section 123100 et seq.; (v) the federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations, 42 CFR Part 2, implementing 42 U.S.C. §290dd-2, each as in effect and as amended from time to time. .

6.2.5 Each party shall implement all necessary policies, procedures, and training to comply with HIPAA and other applicable law, rules and regulations pertaining to the use, maintenance, and disclosure of patient-related information. The parties agree that, for purposes of HIPAA, Group is a "Covered Entity" as such term is defined under HIPAA. As a Covered Entity separate from Hospital, and each party's disclosure of protected health information to the other party under this Agreement shall be a disclosure to a health care provider concerning the treatment of an individual and, therefore, shall not cause a party to become a business associate, as the term is defined at 45 CFR §160.103. Neither party shall be a workforce member or business associate of the other party. In the event that either party will perform services on behalf of the other party involving protected health information that will give rise to a business associate relationship under HIPAA, the parties shall enter into a business associate agreement that complies with HIPAA before engaging in such services.

6.3 Access to Group's Books and Records.

6.3.1 Group shall, in connection with the subject of this Agreement, cooperate fully with Hospital, by, among other things, maintaining and making available all necessary books, documents and records, in order to assure that Hospital will be able to meet all requirements for participation and payment associated with public or private third party payment programs, including matters covered by Section 1861(v)(1)(I) of the Social Security Act, as amended.

6.3.2 For the purpose of implementing Section 1861(v)(1)(I) of the Social Security Act, and any written regulations thereto, Group shall comply with the following statutory requirements governing the maintenance of documentation to verify the cost of services rendered under this Agreement:

6.3.2.1 until the expiration of four (4) years after the furnishing of services pursuant to the Agreement, Group shall make available to the Secretary of Health and Human Services and the Comptroller General of the United States, or their duly authorized representatives, upon written request of any of them, this Agreement, and all books, documents and records that are necessary to certify the nature and extent of the cost of services hereunder, and

6.3.2.2 if Group carries out any of the duties of this Agreement through a subcontract with a value or cost of $10,000 or more over a twelve (12) month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary or the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

6.3.3 If Group is requested to disclose books, documents or records pursuant to this Section, Group shall notify Hospital of the nature and scope of such request.

6.3.4 This Section pertains solely to the maintenance and disclosure of specified records and shall have no effect on the right of the parties to this Agreement to make assignments or delegations.

6.4 Compliance.

6.4.1 Hospital and Medical Staff; Compliance Plan; Discount, Charity Care, Cash-Pay and Self-Pay Policies; Laws and Regulations. Group shall comply with and agrees that each Physician shall comply with (a) Hospital policies, procedures and rules, including without limitation: Hospital's compliance plan and compliance program; Hospital policies and procedures relating to Hospital's implementation and operation of electronic health records and electronic medical records systems and applications; and all of Hospital's discount, charity care, cash-pay, self-pay, and similar policies and procedures as they may relate to the billing of patients at Hospital, (b) the requirements and standards of the Medical Staff Bylaws, (c) federal, state and local laws, rules and regulations, including without limitation all hospital

and professional licensure, corporate practice of medicine, and reimbursement, laws, rules, regulations and policies, , and (d) all standards and recommendations of applicable accreditation agencies, as any of the above may be in effect from time to time, (all such foregoing policies, procedures, rules, Medical Staff Bylaws, laws, regulations, standards and recommendations referred to collectively herein as "Compliance and Related Requirements"). Group's obligations to comply with the Compliance and Related Requirements shall be limited, to the extent applicable, to performance of Specialty Services and/or the exercise of any rights and/or discharge of any duties and obligations hereunder. In no event shall Group be deemed to be in breach of any hospital policy and procedure which Hospital, including, the Medical Staff, has not provided, or otherwise made available and accessible, to Group.

6.4.2 Deficit Reduction Act of 2005. With respect to the Deficit Reduction Act of 2005 ("DRA"), 42 U.S.C. 1396a(a)(68), the Centers for Medicare and Medicaid Services ("CMS") currently takes the position that the law requires certain contractors and agents who deal with the Hospital to adopt Hospital policies which describe the Federal False Claims Act, the applicable State False Claims Act, administrative remedies for false claims, whistleblower protections under Federal and State False Claims Acts, the role of such laws in preventing fraud, waste and abuse, and procedures for detecting and preventing fraud, waste and abuse. In executing this Agreement, Group acknowledges receipt of **Exhibit F** (Hospital policies respecting compliance with the DRA) and accepts the Hospital's compliance plan, program, and policies to the extent required by the law.

6.4.3 Non-Discrimination. Group and Physicians shall not differentiate or discriminate in the provision of Specialty Services due to race, color, national origin, primary language, ancestry, religion, sex, marital status, sexual orientation, gender, transgender status, gender identity, gender expression, age, medical condition, medical history, genetics, evidence of insurability, being a recipient of state or federal financial assistance, physical or mental disability, military and veteran status, claims history, or any other factor in violation of Hospital policies and procedures or any applicable state, federal or local law or regulation, as may be amended from time to time, including but not limited to, the California Unruh Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973 and Titles VI and VII of the 1964 Civil Rights Act.

6.4.4 Knox-Keene. Group and Physicians agree to comply with the Knox-Keene Health Care Services Plan Act of 1975, as amended, and all regulations issued pursuant thereto, applicable to Group's and Physicians' performance of Specialty Services and all other services under this Agreement. Group agrees that in no event, including, but not limited to nonpayment by Hospital or the insolvency of payors or breach of any contracts, will Group or any Physician bill, charge, collect deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a patient or other persons or entities other than Hospital for services which are required to be compensated by Hospital hereunder. Nothing contained herein shall prohibit Group from collecting any coinsurance, co-payment or deductible.

6.4.5 No Requirement for Referrals. Nothing in this Agreement or in any other written or oral agreement between Hospital and Group or any Physician, nor any consideration offered or paid in connection with this Agreement, contemplates or requires the

admission or referral of any patient to Hospital. This Agreement is not intended to influence Group's or any Physician's judgment in choosing the medical facility appropriate for the proper care and treatment of Group's patients.

6.4.6 Anti-Referral Laws. Group acknowledges that it and Physicians may be subject to and, as applicable, shall comply with certain federal and state laws governing referral of patients, as may be in effect or amended from time to time, including:

6.4.6.1 Prohibition on payments for referral or to induce the referral of patients (Cal. Business and Professions Code Section 650; Cal. Labor Code Section 3215; Cal. Welfare and Institutions Code Section 14107.2; and the Medicare/Medicaid Fraud and Abuse Law, Section 1128B of the Social Security Act); and

6.4.6.2 Prohibition on the referral of patients by a physician for certain designated health care services to an entity with which the physician (or his/her immediate family) has a financial relationship (Cal. Labor Code Sections 139.3 and 139.31; Cal. Welfare and Institutions Code Section 14022; Cal. Business and Professions Code Section 650.01 and 650.02; and 42 U.S.C. Section 1395nn and the Stark law and regulations [e.g., Medicare, Medi-Cal, TriCare patients]).

6.4.7 Reference to Master List of Contracts. This Agreement and all other agreements between Hospital and Group shall be included in Hospital's master list agreements, which list is maintained by Hospital and updated centrally, and which shall be made available for review by the Secretary of the Department of Health and Human Services on request in accordance with 42 C.F.R. Section 411.357(d)(ii).

6.4.8 Technology. Group acknowledges that its and Physicians' access to the Hospital's software, computer systems, networks, electronic records, and other technology items and software ("Technology") is a privilege, not a right, and may be automatically suspended or terminated at any time, including without limitation if Group or any Physician fails to comply with the requirements of this Agreement; provided, however, that no such termination of rights shall occur in a manner that will impair Group's ability to provide Specialty Services as required under this Agreement except as such action is taken in connection with a termination of this Agreement as authorized herein. The Technology, including all information created, communicated, processed, or received by the Technology, regardless of where stored, are Hospital property. Group and Physicians acquire no ownership rights in the user identification ("User ID") assigned by Hospital, and such User ID may be revoked or changed at any time in Hospital's sole discretion, subject to compliance with the terms and conditions set forth herein, including, the Medical Staff Bylaws. Group acknowledges and agrees that Group and Physicians have no expectation of privacy in Group's or Physician's access, connection to and use of the Technology, and that, subject to compliance with applicable laws, rules and regulations, Hospital has the right to monitor Physician's access, connection to and use of the Technology. Group and Physicians will access, connect to and use the Technology only for legitimate purposes in connection with Group's and each Physician's performance of professional services for Hospital and in accordance with Hospital policies, procedures and rules. All such policies, procedures and rules are subject to change from time to time at Hospital's discretion and Hospital shall provide notice of any such changes to Group and Physician. Group and each Physician will

complete, execute and comply with any forms, documents or agreements that are required by Hospital for access or use of the Technology and will attend all required training in Technology, privacy, security, and confidentiality matters. Group and Physicians shall not permit any third party, including without limitation third party payors, to access, receive or use any Technology without the prior written approval of Hospital. Group immediately shall notify, and cooperate fully with Hospital in the event Group or any Physician discovers or suspects any unauthorized or improper use of or access to the Technology.

6.5 Coordination and Cooperation. Hospital and Group shall cooperate with respect to any third-party investigations, claims or proceedings that potentially implicate the indemnification provisions set forth in Article IV and/or the prior anesthesia agreement and the delivery of services thereunder, including, but not limited to, the environment and quality of care, and agree to preserve all such documents and to provide to each other, if reasonably requested, any potentially relevant documents in such event to the fullest extent permitted by law. Hospital's and Group's obligations under this Section 6.5 shall be subject to requirements imposed by applicable law and regulations, and to any constraints or limitations imposed by contract or applicable Hospital or Group policies and procedures including without limitation the bylaws and rules and regulations of Hospital's medical staff.

6.6 Intellectual Property.

6.6.1 Preexisting Materials. Each party owns, and will continue to own, all right, title and interest in and to any inventions however embodied, know how, works in any media, software, technology, information, trade secrets, materials, intellectual property rights and proprietary interests that it created or acquired prior to or independently of its obligations under this Agreement (collectively, "Preexisting Materials"). All rights in Preexisting Materials not expressly transferred or licensed herein are reserved to the owner thereof.

6.6.2 Work Product. Any deliverables, work product or other results of the Specialty Services produced through efforts of Group or Physicians under this Agreement, including without limitation, papers, products, processes, works, inventions, discoveries, designs, software in source code and object code forms, techniques, know-how, algorithms, procedures, and all reports, materials, texts, drawings, specifications and other recorded information relating thereto (in each case conceived, reduced to practice, developed, discovered, invented or made by Group or any Physician, whether solely or jointly with others ("Work Product", except that Work Product does not include any Preexisting Materials of Group) shall not be developed using any resources of the Hospital and/or in a manner which otherwise discloses and identifies any data or other information as originating from the Hospital except with the prior written approval of Hospital.

6.7 Dispute Resolution.

6.7.1 Special Meeting. Except as set forth below, in the event of any dispute or disagreement between the parties with respect to this Agreement that is not resolved through ordinary day-to-day administration, Medical Director will meet with the Hospital to attempt to resolve such dispute. In the event that such dispute is not resolved to the satisfaction of the parties following such meeting or reasonable efforts to meet, either party may request in

writing a special meeting for the resolution of the dispute (a "Special Meeting"). The Special Meeting shall be held at a mutually agreeable location within ten (10) days of a written request for the meeting, which request shall specify the nature of the dispute to be resolved. The Special Meeting shall be attended by representatives of Hospital and Group (who may or may not be accompanied by legal counsel, in their respective discretion), who shall attempt in good faith to resolve the dispute and shall have reasonable authority to do so.

6.7.2 Mediation. If a dispute has not been resolved within thirty (30) days after the date of the Special Meeting, the parties shall have fifteen (15) days to initiate mediation by giving written notice thereof to the other party hereto. Both parties shall attend and participate in the mediation, which shall be binding upon the parties if a mutually agreeable resolution is achieved. The mediation proceeding shall commence not more than thirty (30) days after the written notice initiating the mediation process is given by one party to the other party hereto and shall be conducted in the County of Riverside, State of California, by an impartial third party mediator in accordance with the procedures of JAMS/Endispute, Inc., or ADR Services, Inc. This thirty (30) day deadline to commence mediation may be extended by a mutual written agreement of the parties if additional time is needed due to mediator availability. The mediator may be given written statements of the parties and may inspect any applicable documents or instruments. All mediation proceedings shall be attended by representatives of Hospital and Group with reasonable authority to resolve the dispute. The costs and expenses associated with the mediator and the mediation shall be paid equally by Hospital and Group regardless of the result of the mediation proceeding. Further, each party shall bear its own attorneys' fees and costs in connection with the mediation process.

6.7.3 Inadmissibility. The Special Meeting and the mediation proceeding shall be subject to California Evidence Code Sections 1152 through 1157, and 1115 through 1128, inclusive.

6.7.4 No Resolution. In the event a dispute or disagreement between the parties is not resolved pursuant to Section 6.7.1 or 6.7.2 and only after exhaustion of such procedures for resolution, either party may litigate the dispute or disagreement in a court of competent jurisdiction.

6.7.5 Injunctive Relief. Notwithstanding the contrary provisions of this Section 6.7 and except as may be specifically provided for otherwise in this Agreement, each of the parties hereto shall have the right to apply for and obtain a temporary restraining order or other temporary, interim or permanent injunctive or equitable relief from a court of competent jurisdiction in order to enforce the provisions of any part of this Agreement as may be necessary to protect its rights hereunder.

6.7.6 Statute of Limitations. The dispute resolution procedures under Section 6.7 shall toll any statutes of limitation relating to any claim, dispute or other matter arising out of this Agreement, provided that the statute of limitations shall resume running upon completion of the Special Meeting in Section 6.7.1 or mediation in Section 6.7.2, whichever occurs later.

6.7.7 Right Reserved by Parties. The provisions of this Section 6.7 shall not limit, require the postponement of, or in any other way preclude the exercise of any right or remedies otherwise enjoyed by any party hereto under the provisions of this Agreement.

6.8 Binding on Successors in Interest. The provisions of this Agreement and obligations arising hereunder shall extend to and be binding upon and inure to the benefit of the assigns and successors of each of the parties hereto.

6.9 Assignment and Delegation. Except as may otherwise be expressly set forth herein, neither this Agreement nor any of the rights or duties under this Agreement may be assigned or delegated by either party without the prior written consent of other party; provided, however, that either party shall have the right at any time to assign, delegate or in any manner transfer all or any portion of its interests, obligations or duties under this Agreement to any person, group or entity without the consent of the other party in connection with any sale, merger, or other change in ownership or control of a party if (i) the successor entity agrees to assume and any all rights and obligations under this Agreement and (ii) the successor entity is reasonably capable of performing such rights and obligations.

6.10 Notice. Any notice required to be given hereunder shall be in writing and delivered personally, or sent by regular U.S. mail, overnight delivery, or registered or certified mail return receipt requested, or by e-mail, at the applicable addresses listed below, or at such other addresses as a party may hereafter designate to the other or, as applicable, to the e-mail address of the other:

If to Hospital:

San Gorgonio Memorial Hospital
660 N. Highland Springs Ave.
Banning CA 92220
Attention: ____________________

If to Group:

Beaver Medical Group
1615 Orange Tree Lane
Redlands, CA 92374
Attn: Duane Whittington

All notices shall be deemed given on the date of delivery if delivered personally, , or the day following transmittal if delivered by a reputable overnight carrier or three (3) business days after such notice is delivered by overnight mail, registered, or certified mail, or is deposited in the United States mail, addressed and sent as provided for above.

6.11 Severability. The provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the parties.

6.12 Governing Law. The validity, interpretation and performance of this Agreement shall be governed by and construed in accordance with the laws of the State of California and the United States, without giving effect to conflicts of laws principles thereof which might refer such interpretations to the laws of a different state or jurisdiction. Any action

arising under this Agreement shall be adjudicated in the state or federal courts of competent jurisdiction sitting in Riverside County, California, and the parties agree that the foregoing courts are a convenient forum and irrevocably waive any right to object to such venue or to transfer venue, based upon forum non convenience or otherwise.

6.13 Captions. Any captions to or headings of the articles, sections, subsections, paragraphs, or subparagraphs of this Agreement are solely for the convenience of the parties, are not part of this Agreement, and shall not be used for interpretation or determination of the validity of this Agreement or any provision hereof.

6.14 Waiver of Provisions. Any waiver of any terms, covenants and/or conditions hereof must be in writing, and signed by the parties hereto. A waiver of any of the terms, covenants and/or conditions hereof shall not be construed as a waiver of any other terms, covenants and/or conditions hereof, nor shall any waiver constitute a continuing waiver.

6.15 Entire Agreement. The making, execution and delivery of this Agreement by the parties has not been induced by any representations, statements, warranties or agreements other than those herein expressed. This Agreement embodies the entire understanding of the parties, and there are no further or other agreements or understandings, written or oral, in effect between the parties relating to the subject matter hereof, unless expressly referred to by reference herein. This Agreement supersedes any previous oral or written agreements between the parties hereto and any such prior agreement is null and void. This Agreement may be amended or modified only by an instrument in writing signed by both parties to this Agreement.

6.16 Force Majeure. Neither party shall be liable nor deemed to be in default for any delay, interruption or failure in performance under this Agreement deemed resulting, directly or indirectly, from Acts of God, civil or military authority, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or supplies, vandalism, riots, civil disturbances, strike or other work interruptions by either party's employees, or any similar or dissimilar cause beyond the reasonable control of either party. However, both parties shall make good faith efforts to perform under this Agreement in the event of any such circumstances. In the event Hospital determines that it is unable to substantially perform under the Agreement because of any of the forgoing reasons or events, it may terminate the Agreement upon ten (10) days written notice to Group.

6.17 Gender and Number. Whenever the context hereof requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

6.18 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute but one and the same instrument.

6.19 Tax-Exempt Financing. In the event Hospital decides to seek tax-exempt financing, Group agrees to amend this Agreement as may be necessary in order for Hospital to obtain such financing. Immediately upon request by Hospital, Group shall execute any and all

such amendments presented by Hospital and shall return promptly said fully executed original amendments to Hospital.

6.20 Recitals. The Recitals preceding Section 1 of the Agreement are incorporated in and are part of this Agreement.

6.21 Exhibits. The Exhibits hereto are incorporated in and are part of this Agreement.

This Medical Group Professional Coverage and Medical Director Agreement is executed at Banning, California, to be effective on the date first written above.

SAN GORGONIO MEMORIAL HOSPITAL

By: ______________________________

Its: _______________________________

Date: _____________________

[BEAVER MEDICAL GROUP]

By: ________________________________

Its: ________________________________

Date: _________________________

EXHIBIT A

SPECIALTY SERVICES

A. Professional Services: The Group shall be the exclusive provider of Specialty Services for the Hospital's Anesthesia Service.

- **Location:** The Specialty Services to be provided by Group shall include all professional medical services required by Hospital inpatients and outpatients. Except as set forth below, the Specialty Services shall be provided by Group on an exclusive basis with respect to all Hospital inpatients and outpatients, including, without limitation, the following:
    - Operating Rooms
    - Labor and Delivery Suites
    - Specialty Procedure Labs
    - Surgery Centers
    - Outpatient Departments
- **Exclusions.** Notwithstanding any other language set forth in the Agreement, the Group will not provide Specialty Service with respect to the following services or sites:
    - San Gorgonio Memorial Medical Clinic, located at 264 North Highland Springs Avenue, Suite 5A, Banning, CA

B. Coverage.
Group shall provide coverage for the Anesthesia Service at the following levels ("Coverage Services") to ensure that Specialty Services are available to meet all patient care needs for Hospital patients 24 hours a day, 365 days a year.

- **Normal Business Hours.** During the hours 7am to 3PM on Monday through Friday ("Normal Business Hours"): During Normal Business Hours, Group shall make staffing available on-site at the Hospital up to three (3) providers, including, Physicians and a nurse anesthesiologist; provided, however, that average staffing during Normal Business Hours is expected to average of (two (2) FTEs.
- **Non-Business Hours.** At times other than Normal Business Hours ("Non-Business Hours"), Group shall provide one 1 FTE Physician on-site or on-call. If the Physician is on-call, the Physician shall be available to be on-site within 40 minutes of receiving a call for care.
- **Scheduling.** The staffing shall be scheduled and mutually agreed upon by Hospital and Medical Group during the term of the Agreement at such levels as are consistent with professional standards and applicable laws, rules and regulations.

EXHIBIT B

MEDICAL DIRECTOR AND ADMINISTRATIVE SERVICES

"Medical Director" will coordinate and cooperate with leadership of Hospital with respect to the communication and implementation of a demonstrated commitment of the Anesthesia Service to the stated mission and goals of Hospital. The Medical Director is expected to perform medico-administrative services in oversight of the Hospital's "" Anesthesia Service, organize and develop clinical and professional education protocols, and foster communication and teamwork between and among physicians, non-physician clinical staff, and Hospital administration and personnel.

In addition, the Medical Director will perform the following functions, services, and requirements relating to the Anesthesia Service:

1. SPECIFIC EXPECTATIONS

The Medical Director will collaborate with Hospital, and be responsible for medico-administrative services in the Anesthesia Service, including without limitation:

1.1. Oversight of clinical services.

1.2. Perform those duties and responsibilities required by law and regulation, Hospital policies, Hospital Medical Staff Bylaws and rules and regulations, third party payors, and applicable accreditation authorities, copies of which, including notice with respect to any changes therein, shall be provided to, or otherwise made accessible to Medical Group throughout the term of this Agreement.

2. REPORTING RELATIONSHIPS

The Medical Director reports to Corey Fortner, M.D. ("Hospital Liaison"), who shall be authorized to act on behalf of the Hospital.

3. QUALIFICATIONS

Medical Director shall remain, throughout the term of this Agreement,

3.1. Active member of Hospital Medical Staff and Hospital shall take no action to remove Medical Director from the Medical Staff except as authorized under this Agreement or the Medical Staff Bylaws and Rules and Regulations.

3.2. Board certified in anesthesia or meet the educational, training and licensure requirements to sit for the general certifying examination in anesthesia with fellowship training (as applicable).

4. ADMINISTRATIVE LEADERSHIP RESPONSIBILITIES

The Medical Director will with respect to the Anesthesia Service:

4.1. In collaboration with clinical leadership, develop operational policies and procedures for patient care.

4.2. In collaboration with Hospital, assure cost effective and efficient care of patients in the Anesthesia Service.

4.3. Coordinate and cooperate with Hospital regarding the level of support and assistance required by Hospital as required for Medical Director to assume responsibility for complying with the medical director requirements for accreditation by all pertinent regulatory agencies.
4.4. Make recommendations to clinical leadership on the hiring, termination, training and supervision of Hospital personnel to assure compliance with Hospital policies, programs and protocols.
4.5. Meet regularly with the Hospital management team for all anesthesia programs.
4.6. Plan in conjunction with as to equipment needs for both the short and long-term planning.
4.7. Assist Hospital to plan, direct, and implement department programs for patient care, education, and research.
4.8. Serve on medical and administrative committees of the Hospital to effectively represent the Anesthesia Service.
4.9. Facilitate and foster relationships between Hospital based and private practice physicians, including the provision of access and scheduling.
4.10. Perform other duties as may be reasonably requested by Hospital to efficiently and effectively operate the Anesthesia Service.
4.11. Encourage and assist all providers within the Anesthesia Service to comply with Hospital policies and procedures, corporate compliance program standards of conduct, and all applicable statutes, rules and regulations.
4.12. Demonstrate professional conduct in all interactions with other clinicians and staff.

5. PROGRAM DEVELOPMENT

To assist Hospital in achieving Hospital's objective regarding the operation of a high quality, state-of-the-art patient care program, the Medical Director shall with respect to the Anesthesia Service:
5.1. In collaboration with Hospital, participate in a planning process to set reasonable goals and objectives.
5.2. In collaboration with Hospital, assist Hospital staff with respect to the development and presentation to Hospital management a three-year strategic plan that shall recommend clinical advancement relating to the Anesthesia Service.

6. MEDICAL LEADERSHIP/CLINICAL CARE

6.1. Facilitate the operations of the Anesthesia Service in conjunction with support of other members of the Medical Staff.
6.2. Develop standardized clinical protocols for Anesthesia Service patients.
6.3. Encourage the coordination of the continuum of care for patients in the Anesthesia Service.
6.4. Work with other medical specialties of the Hospital to coordinate the care of patients treated with invasive or new therapies applicable to the Anesthesia Service, as they become available and as is needed.

7. PERFORMANCE IMPROVEMENT

To ensure that the quality of care provided by attending staff members meets the standards of the department and serves to further the Hospital's objective of achieving recognition of the Anesthesia Service Hospital as a leader in the provision of high quality medical care, the Medical Director shall work collaboratively with the Medical Staff to:

7.1. Provide continuing oversight of the quality of patient care and professional performance rendered by members in the Anesthesia Service.
7.2. Assure that the medical care carried out by Medical Staff members in the Anesthesia Service is consistent with high quality and evidenced-based medicine.
7.3. Support customer service standards and adhere to these standards on an ongoing basis
7.4. Develop, in conjunction with Hospital, measurable quality and clinical outcomes which can be tracked and trended over time to serve as a measurement of quality of care.

8. UTILIZATION MANAGEMENT
To ensure that resources utilized on behalf of patient care are clinically effective and cost efficient, the Medical Director shall:
8.1. Work collaboratively with physicians in the Anesthesia Service to meet or exceed mutually agreed upon standards necessary to compete in a managed care environment.
8.2. Develop, implement and monitor critical pathways, protocols, or clinical guidelines for high volume/high risk, low volume/high risk and high cost diagnoses within the Anesthesia Service.
8.3. Comply with Hospital-wide performance improvement and utilization management plans.

9. EXTERNAL RELATIONSHIPS
Medical Director shall coordinate with Hospital to favorably increase the visibility of the Anesthesia Service in the community, including, with respect to the following:
9.1. Actively participate, at Hospital’s sole cost and expense, in local, state, and nationally recognized specialty associations determined based on consultation between Medical Director and Hospital in order to enhance the knowledge, image and influence of Hospital.
9.2. Endeavor to coordinate and maintain positive working relationships with the other Hospital Departments.
9.3. Participate as reasonably requested by Hospital, and in accordance with applicable laws, rules, regulations and ethical and accreditation standards, in developing Hospital’s response to the local and national media regarding issues.
9.4. Engage and participate in philanthropic activities at Hospital’s cost and expense, in connection with the Anesthesia Service, as mutually agreed by Medical Director and Hospital.

EXHIBIT C
ACTIVITY LOG FOR MONTH OF _______________

NAME OF PHYSICIAN:____

REPORTING MONTH/YEAR:____ **DEPARTMENT: ANESTHESIA**__________________ **Total hours per month:**__________

NOTE: PLEASE PROVIDE HOURS WORKED IN EACH CELL (ROUND TO NEAREST QUARTER HOUR)

SERVICES PERFORMED	**DATE OF MONTH** (Please enter dates of services provided in the cell below)																						
See Exhibit A for Definition of Specific Services	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
ADMINISTRATIVE & LEADERSHIP TASKS																							
• Develop continuing medical education programs.																							
• Develop operational policies and procedures for care.																							
• Collaboration with Hospital re: cost effective and efficient patient care.																							
• Oversee accreditation compliance requirements for all pertinent regulatory agencies.																							
• Recommend to clinical leadership staffing, training, or supervision of hospital personnel.																							
• Provide ongoing education to staff and units caring for patients.																							
• Participate in all undergraduate and graduate level teaching programs.																							
• Meet regularly with the management team for all programs.																							
• Collaborate with Hospital re: equipment needs for existing/developing programs.																							
• Assist Hospital to plan, direct, & implement patient care, education, & research programs.																							
• Represent program/service on medical and administrative committees.																							
• Facilitate and foster relationships between hospital based and private practice physicians.																							
• Facilitate and ensure compliance of all service providers to Hospital policies and compliance program and all statutes, rules and regulations.																							
PROGRAM DEVELOPMENT																							
• Collaboration in planning process to set goals and objectives.																							
• Collaboration to develop and present a three-year running vision to management.																							
• Develop and implement approved community health education and outreach programs.																							
RESEARCH																							
• Participate as a role model in clinical research.																							

• Present research findings to Hospital and nationally recognized meetings/forums.	
• Publish results from research activities in referred medical journals.	
MEDICAL LEADERSHIP – CLINICAL CARE	
• Facilitate the operations between Hospital and Medical Staff.	
• Develop standardized clinical protocols for Program/Service patients.	
• Promote the coordination of the continuum of care for patients in the Program/Service.	
• Collaboration with other Hospital specialties to coordinate the patient care for patients treated with invasive or new therapies.	
PERFORMANCE IMPROVEMENT	
• Observations of the patient care quality and staff performance.	
• Assure that the medical care provided by Medical Staff is consistent with high quality and evidenced based medicine.	
• Support customer service standards and adhere to these standards on an ongoing basis.	
• Collaborate to develop measurable quality and clinical outcomes.	
UTILIZATION MANAGEMENT	
• Collaboratively with physicians to exceed competitive managed care standards.	
• Develop, implement and monitor critical pathways, protocols, or clinical guidelines.	
• Provide regular education programs for Staff regarding the optimal use of diagnostic and therapeutic procedures for patients.	
• Enforce hospital-wide performance improvement and utilization management plans.	
EXTERNAL RELATIONSHIP	
• Participate in local, state, and nationally recognized specialty associations.	
• Establish and maintain positive working relationships with the anesthesia service.	
• Participate in responding to local and national media regarding issues being overseen.	
• Participate in Program/Service activities for philanthropic purposes.	
OTHER SERVICES PERFORMED NOT SPECIFIED ABOVE. (Please describe)	______________________________
DAILY TOTAL	
PHYSICIAN SIGNATURE:	**DATE:**

EXHIBIT D

THIRD PARTY PAYOR ARRANGEMENTS

Group shall use commercially reasonable efforts and coordinate with Hospital, to the extent permitted by applicable laws, rules and regulation, to enter into Third Party Payor contracts for the provision of Specialty Services with payors with which Hospital has entered into contracts for the provision of hospital services for patients treated by Group.

EXHIBIT E

BILLING AND COMPENSATION

1. Separate Billing for Specialty Services and Hospital Services. Group shall bill, collect and retain any and all revenues, collections and compensation from its separate billing of third-party payors and patients for Specialty Services provided by Group and Physicians . Hospital shall bill separately and retain collections for the facility component of services provided to Hospital patients who are treated by Group and Physicians.

The payments received by Group and Hospital under any arrangements entered into by Hospital with a third-party payor (i) shall be consistent with fair market value and as determined under the allocations set forth under applicable third-party payor agreements, or (ii) if such agreement(s) relates to global fee, risk sharing or does not otherwise provide for such an allocation of amounts to Specialty Services, the amounts payable to Group shall be apportioned equitably between them as determined by mutual written agreement of Hospital and Group; provided, however, that absent such mutual written, Group shall be paid for Specialty Services at an amount equal to: (i) 100% of the Medicare fee-for-service amount for any Specialty Services provided to Medicare Advantage enrollees and (ii) 150% of the Medicare fee-for-service amount for any Specialty Services provided to other non-Medicare patients.

2. Reimbursement at Cost. Except for the Administrative Fee referenced below, Hospital will reimburse Group an amount equal to no more than Group's actualreasonable unreimbursed costs incurred in performing Specialty Services, calculated as the difference between (i) Group's "Coverage Expenses" and (ii) Group's "Collections," as such items shall be determined below:

- **"Collections"** shall be equal to the amount of all collections ("Collections") received by Group with respect to its provision of Specialty Services provided by Group and Physicians under this Agreement.

- **"Coverage Expenses"** shall be equal to the sum of the following reasonable expenses actually incurred by Group in providing Specialty Services, as follows:

    1. **Normal Business Hours.** Group's reasonable costs in providing the staffing levels required for coverage during Normal Business Hours (as described in Exhibit A) to provide the Specialty Services ("Business Hours Coverage") , provided, however, that in no event shall expenses exceed $1,900 per diem per FTE for Business Hours Coverage;

    2. **Non-Business Hours.** Group's reasonable costs in providing the staffing levels required for coverage outside Normal Business Hours (as described in Exhibit A) to provide the Specialty Services ("Non-Business Hours Coverage"); provided, however, that in no event shall expenses included in the Non-Business Hours Coverage exceed $1,000 per diem per FTE to ensure coverage for the Anesthesia Service on weekdays (Monday

through Friday) and $2,200 per diem per FTE to ensure coverage for the Anesthesia Service on weekends and holidays.

3. Payment Rates.

- A. Interim Period. During the Interim Period, (i) Hospital shall reimburse Group for reasonable expenses incurred by Group in providing Specialty Services, net of any collections by Group for the Specialty Services provided by Group during the Interim Period, and (ii) Group shall remit to Hospital any and all collections for Specialty Services provided by persons other than the Group during the Interim Period.
- B. Post-Interim Period. Following the Interim Period, Hospital shall pay Group to the extent of any shortfall between the amount of (i) Group's Coverage Expenses and (ii) Group's collections for Specialty Services provided by Group and Physicians, as follows:
    - On or before the fifteenth (15th) day of each month during the six month period following the expiration of the Interim Period, Hospital shall pay Group a monthly amount of $49,778,[1] that is, the amount equal to the estimated difference between Coverage Expenses and Collections, as projected in accordance with, and subject to, the methodology set forth in this Exhibit E (such amount is hereinafter referred to as "Payment Rate"). The Payment Rate shall be updated during each year of this Agreement for application to services provided in time periods subsequent to the Interim Period, in accordance with the requirements set forth herein.

- **<u>C. True-Up.</u>**
    - 1. **Interim Period.** The amounts owing under the Interim Period shall be settled in accordance with the actually incurred expenses and collections as contemplated under Paragraph 3.A. of this Exhibit E, within thirty (30) days following the Group's submission of supporting documentation which documentation shall be submitted by Group to Hospital not later than thirty (30) days following the month in which services were rendered or collections received, as applicable.
    - **2. Post-Interim Period.** For services provided during periods subsequent to the expiration of the Interim Period, within sixty (60) days following the end of each annual anniversary date of the contract, or if the Agreement is terminated prior to the completion of a year, any such portion of the year thereof, Hospital and Group shall perform a true-up computation to reconcile the difference between (i) the sum of aggregate amounts previously paid by the Hospital during such year under the applicable Payment Rate, plus Collections and (ii) Coverage Expenses, for the prior year or applicable period. Hospital or Group, as the case may be, will pay the other depending on whether there was an aggregate overpayment or underpayment by Hospital.

4. Update of Payment Rate. The Payment Rate shall be subject to update for application to services provided subsequent to the Interim Period, as of each anniversary date of this Agreement, or at such other more frequent intervals as mutually agreed upon by the Parties and as may be reasonably necessary to account for changes in Coverage Expenses or Collections and

to ensure consistency with fair market value. Except as otherwise mutually agreed by the Parties, the Payment Rate during any contract year subsequent to the first year shall be based on: (i) estimated collections in an amount that shall be equal to the actual Collections by Group during the most recent contract year, and (ii) an estimate of expenses based on actual Coverage Expenses incurred by Group during the most recent contract year.

5. Administrative Fee. In addition to the medical director fees payable under Section 1.3, Hospital will pay Group a fee for administration equal to five percent (5%) of the Group's Coverage Expenses.

6. Billing and Collection Services. In exchange for providing Billing and Collection Services for professional Specialty Services rendered by Hospital's physician contractors (other than Group's Physicians) during the Interim Period, Hospital shall pay Group an amount equal to eight percent (8%) of collections obtained for professional services provided by such Hospital contractors during the Interim Period.

7. Documentation. Group shall provide Hospital with an invoice and such other supporting documentation, in a form mutually agreed upon and reasonably acceptable to Hospital, to document the Group's Coverage Expenses and Collections relating to the provision of Specialty Services under this Agreement to document the compensation payable under this Exhibit.

EXHIBIT F

FEDERAL AND STATE FALSE CLAIMS ACTS

UNITED STATES CODE, TITLE 31, SECTIONS 3729-3733
CALIFORNIA GOV'T CODE SEC. 12650 ET. SEQ.
CALIFORNIA WELFARE & INSTITUTIONS CODE SEC. 14107

In accordance with the requirements of the Deficit Reduction Act of 2005, Hospital is required to provide all employees, contractors, and agents of the hospital with information and education on the Federal and State False Claims Acts, whistleblower protections under such laws, related administrative remedies and Hospital's commitment to detecting and preventing fraud, waste and abuse in Federal and state health care programs. As a contractor or agent of the hospital, this document is being given to you in connection with this statutory requirement. Please review this information and share it with your staff or others within your organization who may provide services to, or work with, Hospital.

This information represents a summary of law provided by the Hospital for educational and informational purposes only and does not impact Group's obligations under the Agreement or with respect to compliance with the actual requirements set forth under applicable laws, rule and regulations.

Background
Hospital is committed to complying with all applicable federal and state laws addressing false claims. Accordingly, Hospital is providing the following information to its employees and contractors.

The Federal False Claims Act was signed into law by Abraham Lincoln in 1863 as a way to deter and punish unscrupulous profiteers who were providing substandard supplies to the Union Army. This Act has evolved over time and is used today to protect federal funds from being spent inappropriately due to false or fraudulent claims made to the government. The government spends trillions of dollars each year on health care expenditures for its beneficiaries and the False Claims Act is an effective tool for ensuring that such funds are used appropriately. The State of California has also enacted its own False Claims Act to protect the use of State funds including the Medi-Cal program.

The Federal False Claims Act
The Federal False Claims Act imposes civil liability (including substantial monetary penalties and damages) on any person or corporation which does any of the following:

- knowingly presents or causes to be presented a false or fraudulent claim for payment to the government for payment or approval;
- knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;
- has possession, custody, or control of property or money used (or to be used) by the government and knowingly delivers, or causes to be delivered, less than all of that money or property to the government;
- certifies receipt of property used (or to be used) by the government on a document without completely knowing that the information is true;
- knowingly buys or receives government property from an unauthorized agent; or
- knowingly makes, uses or causes to be made or used, a false record or statement material to an "obligation" to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government; or

- engages in a conspiracy to commit any of the above actions.

Any overpayment retained by a person or corporation after the deadline for reporting and returning the overpayment is now defined as an "obligation" such that failing to return an overpayment where an obligation to do so exists results in a false claim.

Under the False Claims Act, the term "claim" means any claim for payment presented to the government, its agent (e.g., an officer or employee of the government), or its contractor (e.g., independent contractor, grantee or other recipient if the money or property is to be used on the government's behalf).

Violations of the Federal False Claims Act can result in civil monetary penalties and fines ranging from $11,463 to $22,927 (per the March 1, 2019 Federal Register) per false claim, a repayment of up to triple the amount of damages to the government and possible exclusion from participation in federally-funded health care programs. A person violating the Federal False Claims Act shall also be liable for the costs of a civil action brought to recover any such penalty or damages.

The statute defines *knowing* and *knowingly* as requiring no proof of specific intent to defraud and meaning that the person (1) has actual knowledge of the information, (2) acts in deliberate ignorance of the truth or falsity of the information, or (3) acts in reckless disregard of the truth or falsity of the information.

Administrative Remedies

In addition to the penalties described above, separate administrative remedies for false claims and statements also may be imposed by the government. Under the general federal Administrative Remedies for False Claims and Statements statute, each false claim may result in the imposition of administrative civil penalties of up to $5,000, plus twice the amount claimed, or such other amount as may be required by law. .

Whistleblower Protection

The False Claims Act allows a private individual, referred to as a whistleblower or *qui tam relator*, to bring a civil action in the name of the United States. The purpose of the *qui tam* provision is to give an incentive to whistleblowers to come forward to help the government discover and prosecute fraudulent claims by awarding them a percentage of the amount recovered. Generally, relators are entitled to 15 percent to 35 percent of the amount the government recovers as a result of the *qui tam* lawsuit. Over the past few years, *qui tam* cases filed under the False Claims Act have accounted for the majority of civil fraud cases pursued by the government.

There are specific protections afforded to employees of Hospital who come forward expressing concerns about possible legal and regulatory concerns including violations of the False Claims Act. Such protections are afforded to any employee who was discharged, demoted, suspended, harassed, threatened, denied a promotion or in any manner discriminated against by their employer because of their participation as a whistleblower.

California False Claims Act

California has passed laws expanding the prohibition against the submission of false claims in the context of the Medi-Cal program. California's civil False Claims Act is modeled on the federal law and provides for monetary penalties of up to $10,000 per claim, plus three times the amount of damages sustained by the state. *Qui tam* actions are permitted under the California false claims statute as well. Additionally,

employers are not permitted to interfere with employees' disclosure or initiation of false claims actions. California law prohibits employers, such as Hospital, from discharging, demoting, suspending, threatening, harassing, denying promotion to or otherwise retaliating against any employee based on his or her initiation of or participation in a false claims action.

California Medicaid Antifraud Statute

California Welfare & Institutions Code Section 14107 prohibits fraud involving funds of the state's medical assistance programs, including Medi-Cal. This statute establishes grounds for both criminal and civil actions against any person who knowingly defrauds Medi-Cal or other state medical assistance programs by submitting false claims or making false representations. Actions under this statutory provision may only be brought by state officials. Private individuals cannot file *quit tam* lawsuits under this provision, although the state may offer monetary rewards of up to $1,000 to individuals who provide information leading to recovery of fraudulently obtained funds. Penalties for a violation of this statute include imprisonment and/or a fine not exceeding three times the amount or value of the fraud.

Hospital's Compliance Program

Hospital is committed to compliance with all laws and regulations that govern the operations of its business. As a means of improving and ensuring compliance, Hospital has instituted a Compliance Program which is designed to establish a culture within the organization that promotes prevention, detection and resolution of instances of conduct that do not conform with Federal or State laws and private payer requirements. The Compliance Program is overseen by a Compliance Officer who is charged with ensuring that the Compliance Program operates in a manner that is effective in meeting its intended purposes based on the recommendations of the Office of Inspector General of the Department of Health and Human Services.

Asking Questions and Reporting Concerns

If you, or someone within your organization, has a question about a potential legal or regulatory concern, including the False Claims Act, or if you have observed something that you believe may place you, your organization or the hospital at risk for a compliance concern, there are a number of avenues available to have your questions answered or your concerns addressed. Hospital's Compliance Officer is available as a resource to answer questions or address concerns. The Compliance Officer can be reached at ________[2] during regular business hours or after hours and on weekends through the hospital's switchboard operator. Hospital also has a Compliance Hotline that is available 24 hours a day, 7 days a week. The Compliance Hotline serves to have questions and concerns addressed in an effective manner and to protect confidentiality and identity of the person placing the call.

While we encourage all individuals to bring questions and concerns directly to the attention of the hospital, calls can also be placed directly with the appropriate government authorities.

Nonretaliation

Hospital maintains a strict non-retaliation policy. This means that if concerns are expressed about an issue or a violation, the person reporting such concerns will not be punished or retaliated against in any

[2] Open.

way for expressing such concerns. This policy helps to protect those who come forward in good faith to report a concern that they believe could be a legal or regulatory risk.

Additional Resources

Hospital's Compliance Hotline:

Department of Health and Human Services Officer of Inspector General Hotline
(800) HHS-TIPS (800-447-8477)

If you have questions pertaining to this document or would like further information, please contact Hospital's Compliance Office at: ____________________

TAB G

STATE OF CALIFORNIA
GOVERNOR'S OFFICE OF EMERGENCY SERVICES
Cal OES 130

Cal OES ID No: ____________________

DESIGNATION OF APPLICANT'S AGENT RESOLUTION #2020-03
FOR NON-STATE AGENCIES

BE IT RESOLVED BY THE Hospital Board (Governing Body) OF THE San Gorgonio Memorial Hospital (Name of Applicant)

THAT Stephen Larson - Managing Principal (Title of Authorized Agent), OR

William Webster - Principal (Title of Authorized Agent), OR

Kathy Mendoza - Senior Associate (Title of Authorized Agent)

is hereby authorized to execute for and on behalf of the San Gorgonio Memorial Hospital (Name of Applicant), a public entity established under the laws of the State of California, this application and to file it with the California Governor's Office of Emergency Services for the purpose of obtaining certain federal financial assistance under Public Law 93-288 as amended by the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988, and/or state financial assistance under the California Disaster Assistance Act.

THAT the San Gorgonio Memorial Hospital (Name of Applicant), a public entity established under the laws of the State of California, hereby authorizes its agent(s) to provide to the Governor's Office of Emergency Services for all matters pertaining to such state disaster assistance the assurances and agreements required.

Please check the appropriate box below:

☒ This is a universal resolution and is effective for all open and future disasters up to three (3) years following the date of approval below.
☐ This is a disaster specific resolution and is effective for only disaster number(s) ____________________

Passed and approved this __________ day of ________________, 20_____

____
(Name and Title of Governing Body Representative)

____
(Name and Title of Governing Body Representative)

____
(Name and Title of Governing Body Representative)

CERTIFICATION

I, ______________________ (Name), duly appointed and ______________________ (Title) of ______________________ (Name of Applicant), do hereby certify that the above is a true and correct copy of a Resolution passed and approved by the ______________________ (Governing Body) of the ______________________ (Name of Applicant) on the ______________ day of ______________, 20___.

______________________ (Signature) ______________________ (Title)

Cal OES Form 130 Instructions

A Designation of Applicant's Agent Resolution for Non-State Agencies is required of all Applicants to be eligible to receive funding. A new resolution must be submitted if a previously submitted Resolution is older than three (3) years from the last date of approval, is invalid or has not been submitted.

When completing the Cal OES Form 130, Applicants should fill in the blanks on page 1. The blanks are to be filled in as follows:

Resolution Section:

Governing Body: This is the group responsible for appointing and approving the Authorized Agents.
Examples include: Board of Directors, City Council, Board of Supervisors, Board of Education, etc.

Name of Applicant: The public entity established under the laws of the State of California. Examples include: School District, Office of Education, City, County or Non-profit agency that has applied for the grant, such as: City of San Diego, Sacramento County, Burbank Unified School District, Napa County Office of Education, University Southern California.

Authorized Agent: These are the individuals that are authorized by the Governing Body to engage with the Federal Emergency Management Agency and the Governor's Office of Emergency Services regarding grants applied for by the Applicant. There are two ways of completing this section:

1. Titles Only: If the Governing Body so chooses, the titles of the Authorized Agents would be entered here, not their names. This allows the document to remain valid (for 3 years) if an Authorized Agent leaves the position and is replaced by another individual in the same title. If "Titles Only" is the chosen method, this document must be accompanied by a cover letter naming the Authorized Agents by name and title. This cover letter can be completed by any authorized person within the agency and does not require the Governing Body's signature.

2. Names and Titles: If the Governing Body so chooses, the names **and** titles of the Authorized Agents would be listed. A new Cal OES Form 130 will be required if any of the Authorized Agents are replaced, leave the position listed on the document or their title changes.

Governing Body Representative: These are the names and titles of the approving Board Members.
Examples include: Chairman of the Board, Director, Superintendent, etc. The names and titles **cannot** be one of the designated Authorized Agents, and a minimum of two or more approving board members need to be listed.

Certification Section:

Name and Title: This is the individual that was in attendance and recorded the Resolution creation and approval.
Examples include: City Clerk, Secretary to the Board of Directors, County Clerk, etc. This person **cannot** be one of the designated Authorized Agents or Approving Board Member (if a person holds two positions such as City Manager and Secretary to the Board and the City Manager is to be listed as an Authorized Agent, then the same person holding the Secretary position would sign the document as Secretary to the Board (not City Manager) to eliminate "Self Certification."

TAB H

CNO REPORT TO THE BOARD

MAY 2020

Patient Care Quality and Safety:

Most of the patient activity for the last 2 months has centered on providing care and treatment to Covid 19 positive patients and patients under investigation. Below are some of the measures taken to deal with the situation at our facility.

On 3/18/2020 we received a program flex to establish a triage tent in the ED parking lot so that we could separate the potentially infectious patients from the other regular ED patients. The tent was set up and we started seeing patients in the tent on March 20th. This process has worked well for keeping both patients and staff safe. Our ED was built with 2 negative pressure rooms for isolating patients. This is quite adequate in normal circumstances. However, because of the influx of potential Covid patients, we have temporarily increased our isolation capacity to seven rooms through the use of rental equipment and some small modifications.

Mid- March all elective surgeries and procedures were cancelled. Only emergent cases are being done. At this time we are looking at the process for beginning to reopen surgery and the GI lab for the more urgent elective cases.

On March 15th we began to limit visitors to 1 immediate family member at a time and on April 6th we closed the hospital to visitors. We still remain closed to visitors at this time.

A surge plan was established for both the ED and the inpatient areas. These plans are fluid documents that are reassessed weekly and revised as needed. At this time we are using the ICU/DOU for all potential infectious patients regardless of their acuity status. Nurses from other units are floating to the ICU to assist in the care of these patients. All 16 of the ICU/DOU rooms have been converted to negative pressure isolation rooms and, as part of our surge plan, we have modified spaces so that we can place 2 Covid positive patients together in a room, as needed.

We prepared ahead and have managed our supply of personal protective equipment (PPE) sensibly. As a result, we are more fortunate than many institutions, as our supplies are holding out well. We have also been blessed to have donations of PPE from several sources. The largest donations came from Harbor Freight and Home Depot. This has been very helpful in preserving our PPE supplies.

Our staff has truly risen to the occasion to care for these patients and their families. Their flexibility, stamina and compassion have been unwavering. Their capacity to care for these patients and each other is a blessing for the patients the hospital and the community. I am very proud of our associates and honored to be a part of this team.

TAB I

San Gorgonio Memorial Hospital Implementation Strategy Report

2020-22

Table of Contents

Letter from CEO 3

Executive Summary 4

San Gorgonio Memorial Hospital Overview 5

Community Benefits Team 16

Invitation to a Healthier Community 17

Community Health Needs Assessment Overview 19

2019 CHNA Identified Needs – Addressing Needs 22

Identified Needs from CHNA, Not Addressed 27

Making a Difference: Evaluation of 2016 CHNA 28

Strategic Partner List 32

Financial Assistance Policies 33

Approval Page 34

Letter from CEO

Dear Community,

San Gorgonio Memorial Hospital (SGMH) has engaged in and completed an intensive process that has been developed out of both primary and secondary research, to assess the community's health needs. The process resulted in the identification of needs and then the Board of Directors review and selection of health needs that they felt the organization could impact over the course of the next 3 years. The 2019 Community Health Needs Assessment which includes the Community Health Implementation Plan, is a requirement of the Affordable Care Act of 2010 which is a process with the goals of impacting the community health needs in a structured manner. The process involved rigorous assessment and analysis and identifying programs and collaboration thru community partnerships to make a difference in the health needs of the community. Thank you to all that participated from the community. We are looking forward to another 3 years of partnering with the community thru the many programs we continue to engage in as well as new programs, to improve the community health needs that we see impacting our local and regional area.

Sincerely,

Steve Barron, CEO
San Gorgonio Memorial Hospital

Executive Summary

Introduction and Purpose

San Gorgonio Memorial Hospital (SGMH) is pleased to share its Community Health Implementation Strategy. This follows the development of its 2019 Community Health Needs Assessment (CHNA) in accordance with requirements in the Affordable Care Act. The Community Health Needs Assessment (CHNA) represents our commitment to improving health outcomes in our community through rigorous assessment of health status in our market, incorporation of stakeholder's perspectives, and adoption of related implementation strategies to address priority health needs. The CHNA is conducted not only to partner for improved health outcomes but also to satisfy our annual community benefit obligations by meeting requirements that are outlined in section 501(r)(3) of the Federal IRS Code, as well as, under the Affordable Care Act of 2010. The goals of this assessment were to:

- Engage public health and community stakeholders including low-income, minority, and other underserved populations
- Assess and understand the community's health issues and needs
- Understand the health behaviors, risk factors, and social determinants that impact health
- Identify community resources and collaborate with community partners
- Use assessment findings to develop and implement a Community Health Plan (implementation strategy) based on the Hospital's prioritized issues.

Identified Needs

The results of the CHNA guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, San Gorgonio Memorial Hospital has adopted the following priority areas for our community health investments for 2019-2022:

- Prevention and Management of Chronic Diseases
  - Diabetes
  - Obesity
  - Asthma
  - Heart Disease
  - Cancer
  - Nutrition & Physical Activity
- Access to Health Services
  - Affordability/Insurance
  - Transportation
  - Shortage of primary care and specialty physicians
- Mental and Behavioral Health
  - Substance Abuse
  - Intensive outpatient Program

Building a healthy environment requires multiple stakeholders working together with a common purpose. We invite you to join us as we imagine a healthier region and collectively work together to find solutions to create a healthier community for all.

San Gorgonio Memorial Hospital Overview

Hospital Identifying Information

San Gorgonio Memorial Hospital (SGMH) is located in Banning, California, a rural area in the northwestern portion of Riverside County, between Riverside and Palm Springs. The SGMH District area is populated by approximately 95,000 year-round residents. SGMH is the only acute care hospital within the District's boundaries, commonly referred to as the San Gorgonio Pass area and includes the communities of Banning, Beaumont, Calimesa, Cabazon, Cherry Valley, and Whitewater.

Mailing Address: 600 N Highland Springs Ave, Banning, CA 92220
Contact Information: Holly Yonemoto, 951-846-2868
Website: https://sgmh.org

Mission, Vision and Values

Mission Statement: To provide safe, high-quality, personalized healthcare services.

Our Vision: Patients trust San Gorgonio Memorial Hospital to provide safe, personalized healthcare services.

Our Values:

- We make those we serve our highest priority
- We respect privacy and confidentiality
- We communicate effectively
- We conduct ourselves professionally
- We have a sense of ownership
- We are committed to each other and to our community

Hospital Service Area

A hospital service area is "defined" as the geographic area where a hospital receives the majority of hospital admissions. Service areas are divided into two subsets, "primary" and "secondary". The data source for the patient zip codes was derived from the 2017 Services/Discharges from the Office of Statewide Health Planning and Development (OSHPD) file using the SpeedTrack analytics platform.

Service Area

Primary Service Area (PSA)

Zip Code	% Patients	City
92220	38.58	Banning
92223	31.10	Beaumont

Secondary Service Area (SSA)

Zip Code	% Patients	City
92230	3.87	Cabazon
92399	3.79	Yucaipa
92583	2.81	San Jacinto
92320	2.29	Calimesa
92544	1.78	Hemet
92543	1.41	Hemet
92582	1.16	San Jacinto
92545	1.14	Hemet

Community Profile - Riverside County Quick Facts - 2019

Key Facts

2,447,782
Population

34.8
Median Age

3.2
Average Household Size

$65,079
Median Household Income

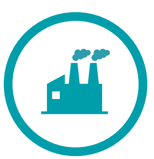
Households by Income

Income	Percent
<$15,000	14.5%
$15,000 – $24,999	12.3%
$25,000 – $34,999	11.3%
$35,000 – $49,999	17.1%
$50,000 – $74,999	19.8%
$75,000 – $99,999	10.3%
$100,000 – $149,999	10.1%
$150,000 – $199,999	2.5%
$200,000+	2.1%

Education

18%	27%	33%	23%
No High School Diploma	High School Graduate	Some College	Bachelors/Grad/ Prof Degree

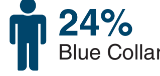
Business



67,683
Total Businesses

659,644
Total Employees

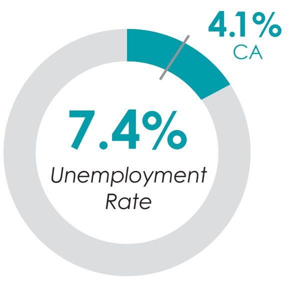
Employment



56% White Collar

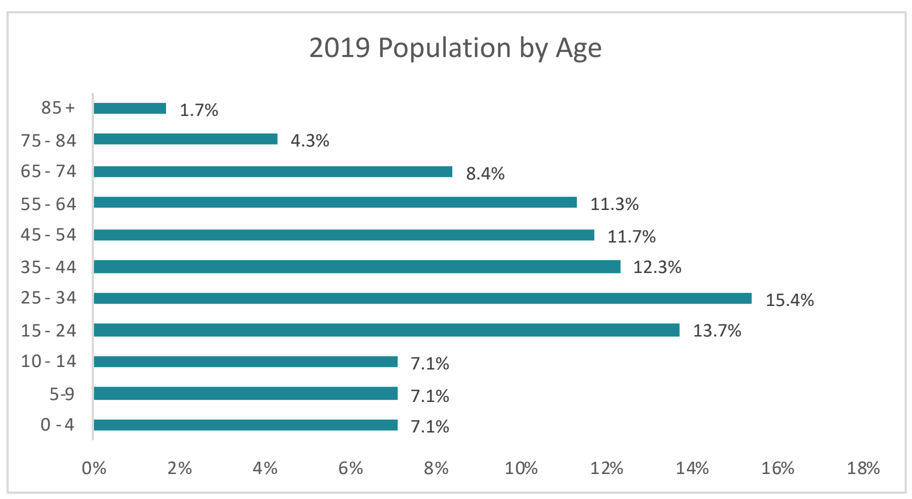
24% Blue Collar

20% Services



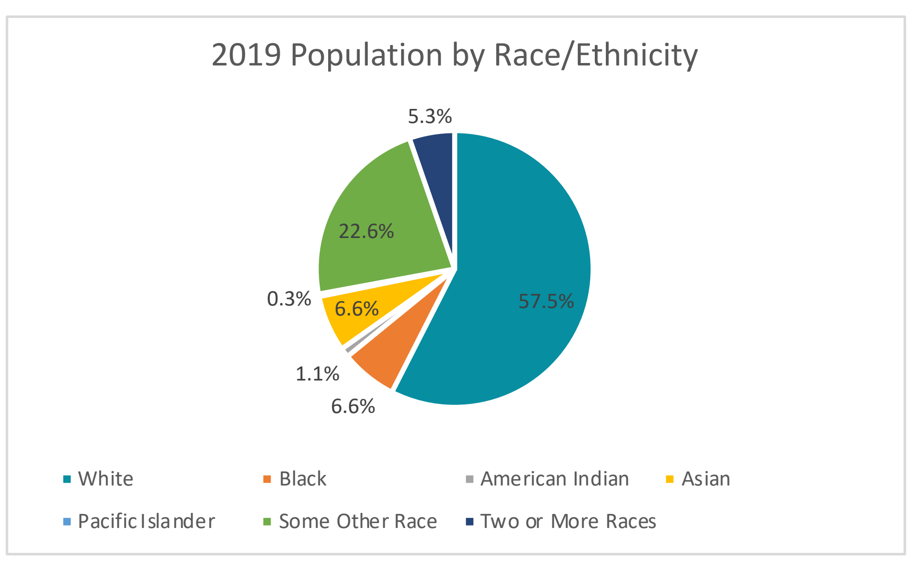
Data Source: U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

Community Profile - Riverside County Quick Facts - 2019



2019 Population by Sex

Males	1,216,146
Females	1,231,636

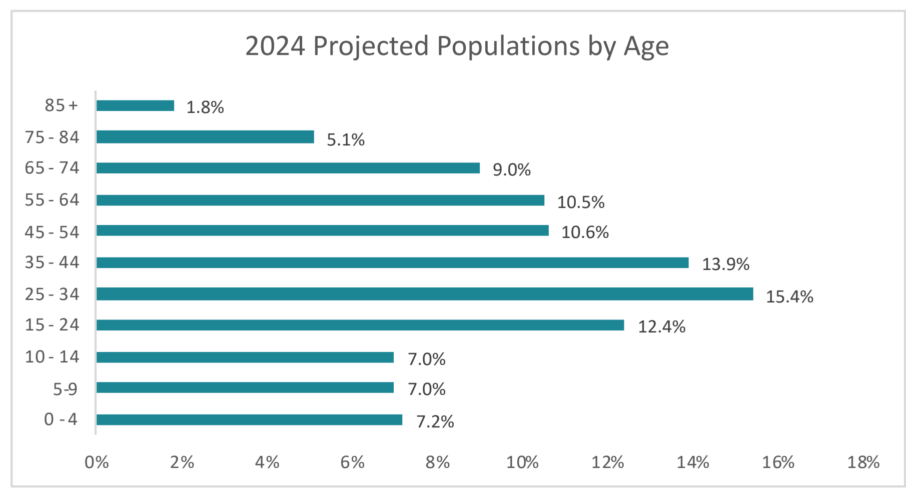


2019 Population by Race

Hispanic Origin	50%

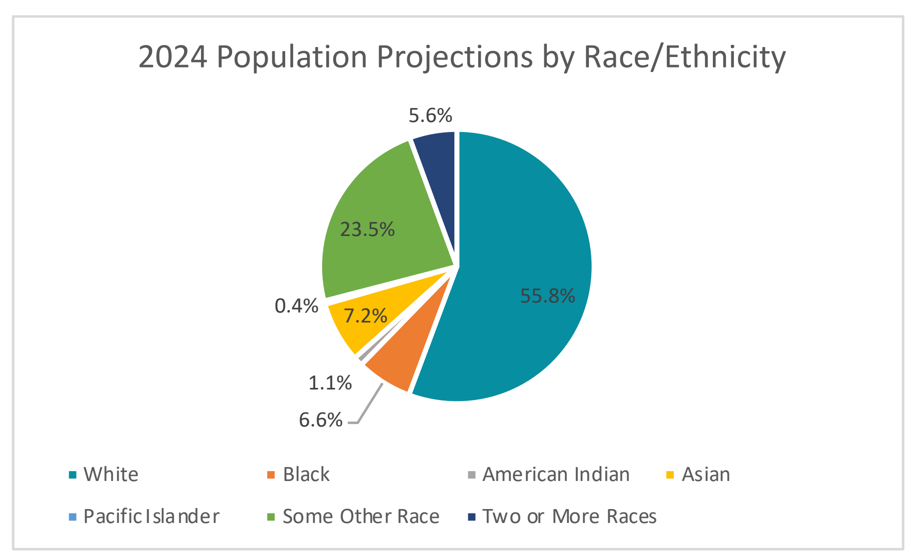
Data Source:U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

Community Profile - Riverside County Quick Facts - 2024 Projections



2024 Population by Sex

Males	1,289,976
Females	1,307,570



2024 Population by Race

Hispanic Origin	52.7%

Data Source:U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

Community Profile - Banning Quick Facts - 2019

Key Facts

30,788
Population

41.9
Median Age

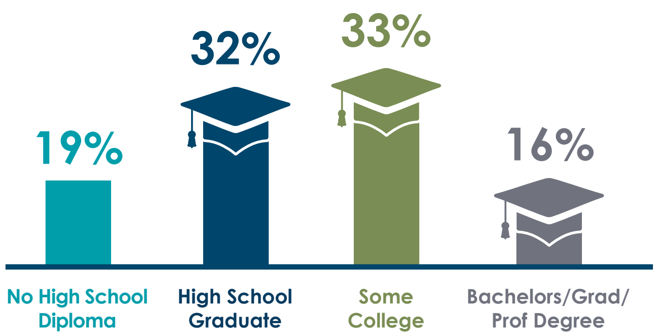
2.6
Average Household Size

$44,294
Median Household Income

Households by Income

Income	Percent
<$15,000	14.5%
$15,000 – $24,999	12.3%
$25,000 – $34,999	11.3%
$35,000 – $49,999	17.1%
$50,000 – $74,999	19.8%
$75,000 – $99,999	10.3%
$100,000 – $149,999	10.1%
$150,000 – $199,999	2.5%
$200,000+	2.1%

Education

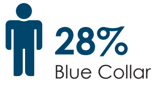


Business

710
Total Businesses

7,121
Total Employees

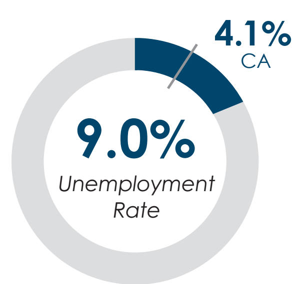
Employment



49% White Collar

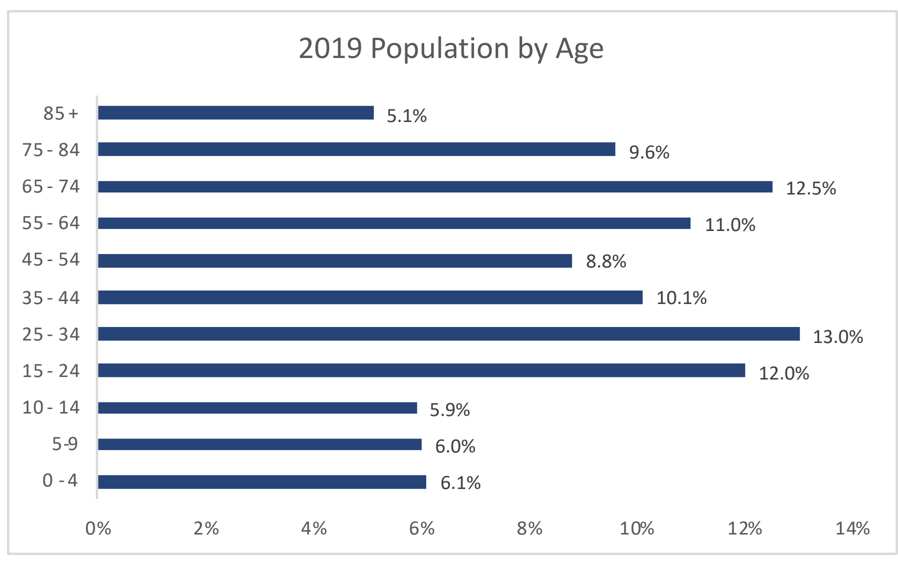
28% Blue Collar

23% Services



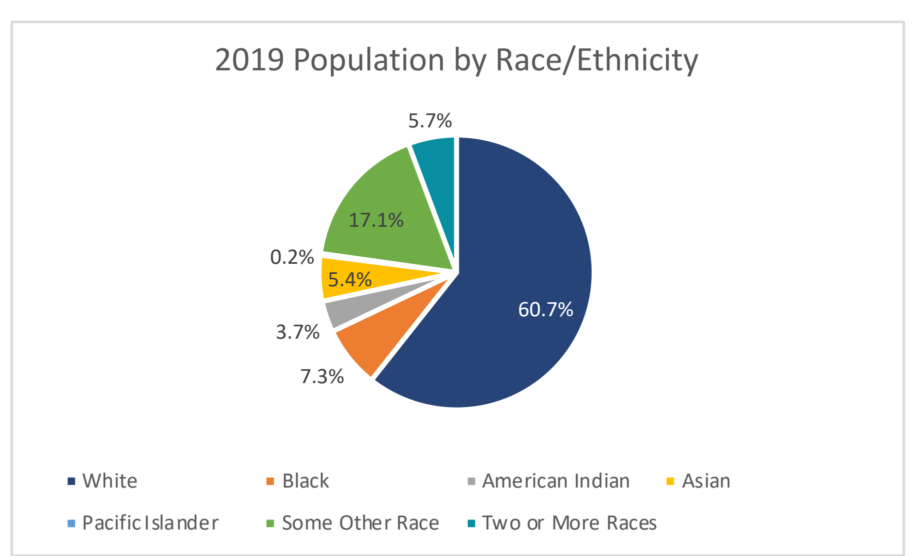
Data Source: U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

Community Profile - Banning Quick Facts - 2019



2019 Population by Sex

Males	16,107
Females	17, 040

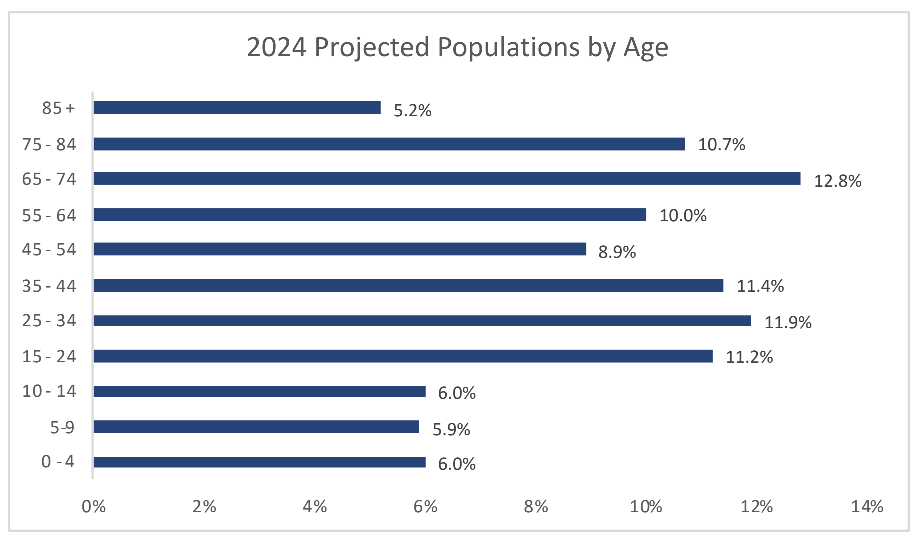


2019 Population by Race

Hispanic Origin	45.3%

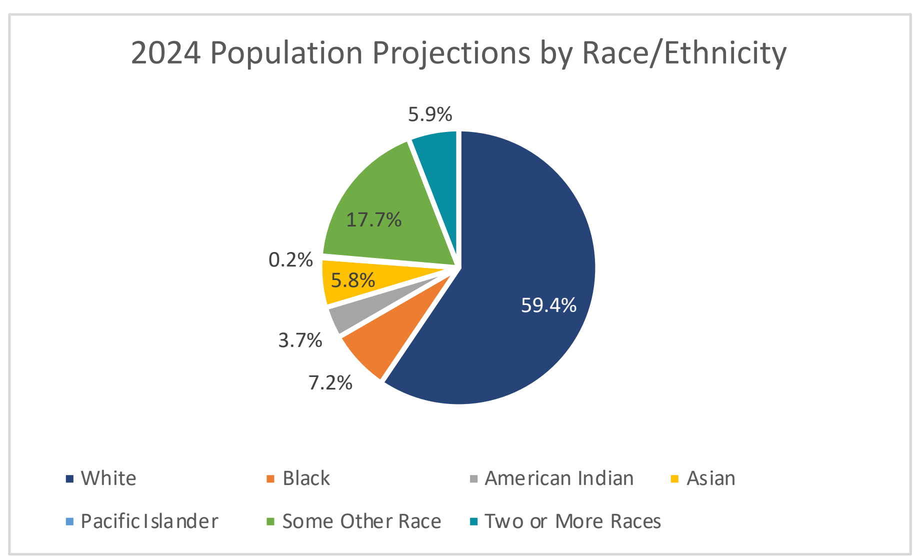
Data Source:U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

Community Profile - Banning Quick Facts - 2024 Projections



2024 Population by Sex

Males	17, 012
Females	17, 845



2024 Population by Race

Hispanic Origin	48%

Data Source:U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

Community Profile - Beaumont Quick Facts - 2019

Key Facts

48,995
Population

36.2
Median Age

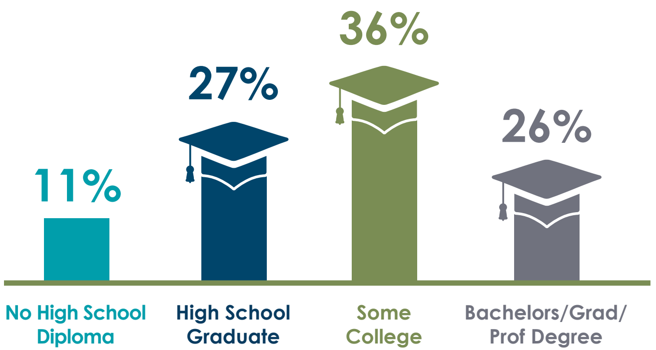
3.1
Average Household Size

$76,507
Median Household Income

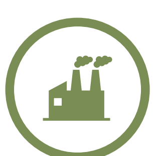
Households by Income

Income	Percent
<$15,000	8.8%
$15,000 – $24,999	6.1%
$25,000 – $34,999	6.4%
$35,000 – $49,999	11.3%
$50,000 – $74,999	16.3%
$75,000 – $99,999	13.6%
$100,000 – $149,999	22.9%
$150,000 – $199,999	7.3%
$200,000+	7.4%

Education



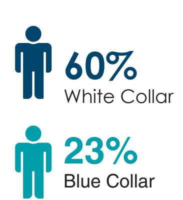
Business

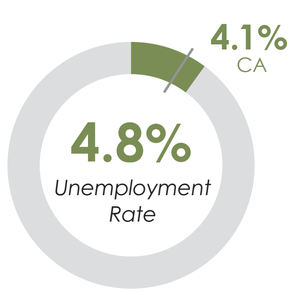


834
Total Businesses

7,875
Total Employees

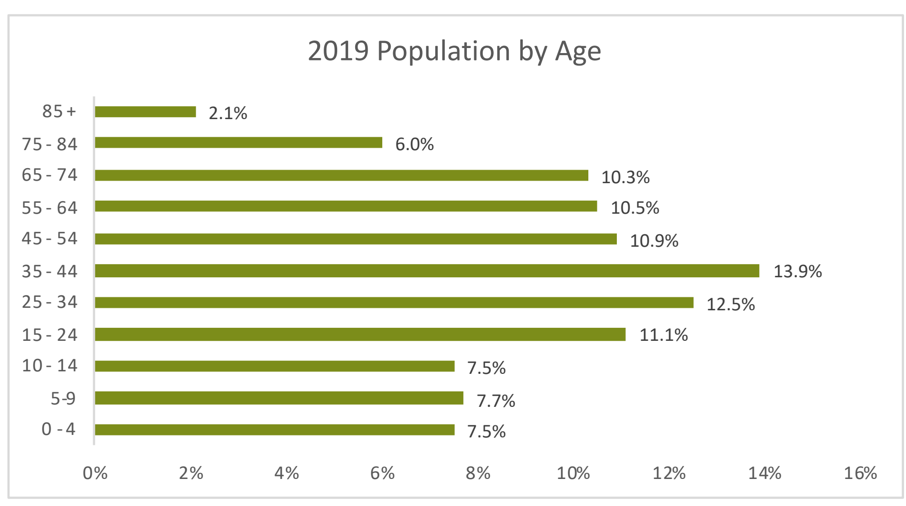
Employment





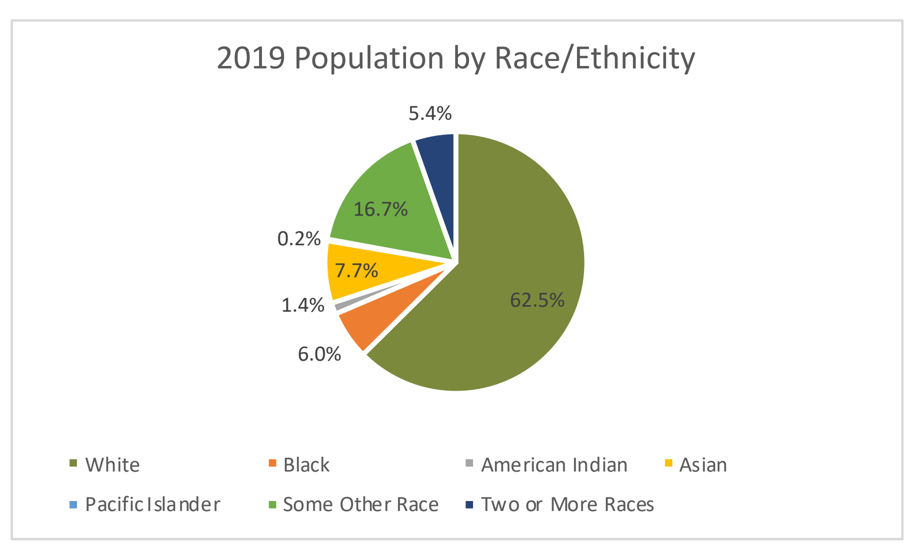
Data Source: U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

Community Profile - Beaumont Quick Facts - 2019



2019 Population by Sex

Males	26,920
Females	28, 510

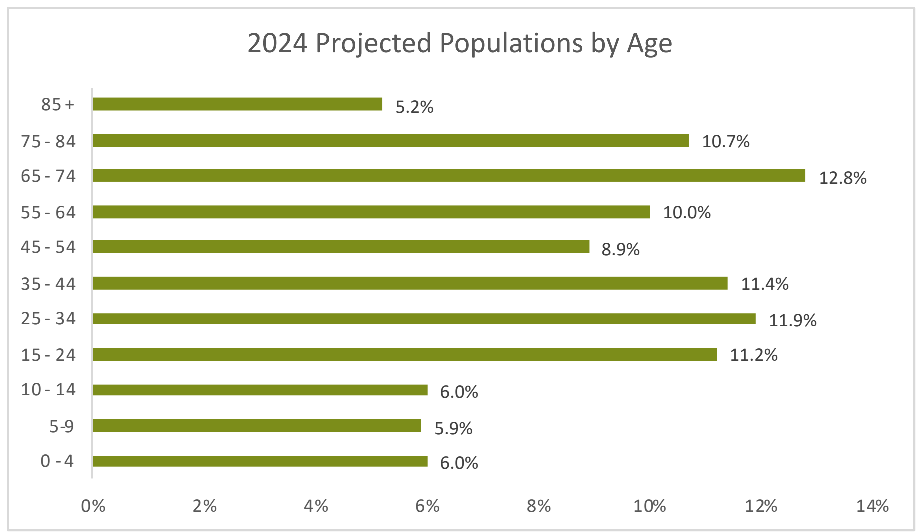


2019 Population by Race

Hispanic Origin	41.8%

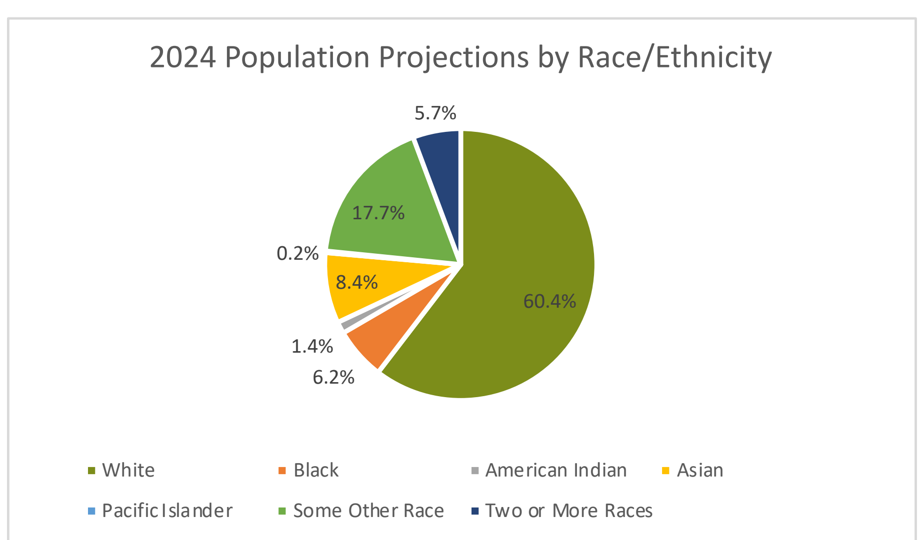
Data Source:U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

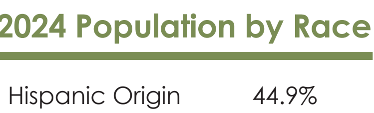
Community Profile - Beaumont Quick Facts - 2024 Projections



2024 Population by Sex

Males	29, 494
Females	31, 257





2024 Population by Race

Hispanic Origin	44.9%

Data Source:U.S. Census Bureau, Census 2010 Summary File 1. Esri forecasts for 2019 and 2024 Esri converted Census 2000 data into 2010 geography. Retrieved October 2019.

Community Benefits Team

CHNA/CHP contact:

Holly Yonemoto, MBA Chief Business Development Officer
600 N Highland Springs Ave, Banning, CA 92220

Phone number: (951) 846-2868 Email: hyonemoto@sgmh.org

To request a copy, provide comments or view electronic copies of current and previous community health needs assessments or community benefit implementation strategies, please visit

http://bit.ly/sgmh-CHNA

Invitation to a Healthier Community

Fulfilling our Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must take into account health behaviors and risks, the physical environment, the health system, and social determinants of health. Each component influences the next and through strategic and collective action improved health can be achieved.

The Community Health Implementation Plan (CHIP) marks the second phase in a collaborative effort to systematically investigate and identify our community's most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address through the use of our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission to "To provide safe, high-quality, personalized healthcare services."

Identified Needs

The results of the CHNA guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, San Gorgonio Memorial Hospital has adopted the following priority areas for our community health investments for 2019-2022:

- Prevention and Management of Chronic Diseases
  - Diabetes
  - Obesity
  - Asthma
  - Heart Disease
  - Cancer
  - Nutrition & Physical Activity

- Access to Health Services
  - Affordability/Insurance
  - Transportation
  - Shortage of Primary Care and Specialty Physicians

- Mental and Behavioral Health
  - Substance Abuse
  - Intensive Outpatient Program

Additionally, we engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Are our interventions making a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population's health status?

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.

Community Health Needs Assessment Overview

Link to final CHNA report

Our CHNA was approved and published in December 16,2019. The CHNA can be downloaded from our website: http://bit.ly/sgmh-CHNA

Methodology for CHNA

Developing metrics for population health interventions are imperative for continued success in elevating the health status of our communities. Including metrics from multiple sectors ensures a holistic assessment that views the health of a community through multiple sectors, helping to identify everyone's role in making improvements. The community health needs assessment (CHNA) ensures we can target our community investments into interventions that best address the needs of our community. The domains used in this regional CHNA encompass national and state community health indicators. While we recognize that health status is a product of multiple factors, each domain influences the next and through systematic and collective action improved health can be achieved. The domains explored in the CHNA are:

- **Social and Economic Factors:** Indicators that provide information on social structures and economic systems. Examples include poverty, educational attainment, and workforce development.
- **Health Systems:** Indicators that provide information on health system structure, function, and access. Examples include health professional shortage areas, health coverage, and vital statistics.
- **Public Health and Prevention:** Indicators that provide information on health behaviors and outcomes, injury, and chronic disease. Examples include cigarette smoking, diabetes rates, substance abuse, physical activity, and motor vehicle crashes.
- **Physical Environment:** Indicators that provide information on natural resources, climate change, and the built environment.

Secondary Data Sources

Secondary sources include publicly available state and nationally recognized data sources available at the zip code, county, and state level. Health indicators for social and economic factors, health system, public health and prevention, and physical environment are incorporated. The top leading causes of death as well as conditions of morbidity that illustrate the communicable and chronic disease burden across Riverside County are included. A significant portion of the data for this assessment was collected through a custom report generated through CARES Engagement Network CHNA (https://engagementnetwork.org/assessment/). Other sources include California Department of Public Health, County Health Rankings & Roadmaps, and California Environmental Protection Agency's Office of Environmental Health Hazard Assessment. When feasible, health metrics have been further compared to estimates for the state or national benchmarks, such as the Healthy People 2020 objectives.

Inpatient hospitalization discharge data for 2017 was derived from the California Office of Statewide Health Planning and Development (OSHPD) utilizing the SpeedTrack analytics platform. Hospitalization discharge data is stratified by gender, race/ethnicity and age, and data containing an n-value of 10 or less were not included in the tables and graphs were not generated.

Primary Data Sources

To validate data and ensure a broad representation of the community, the San Gorgonio CHNA Workgroup engaged our community partners to conduct a community health survey. Questions from the survey focused on: use of and access to healthcare services, visions of a healthy community, and priority community health needs. In addition, the San Gorgonio CHNA Workgroup conducted key informant interviews and focus groups. An online survey in English and Spanish was also distributed to gather more rich data and aid in describing the community. Results of the qualitative analysis can be found later in this document.

Data Limitations and Gaps

It should be noted that the survey results are not based on a stratified random sample of residents throughout Riverside and San Bernardino counties. The perspectives captured in this data simply represent the community members who agreed to participate and have an interest. In addition, this assessment relies on several national and state entities with publicly available data. All limitations inherent in these sources remain present for this assessment.

Collaborative Partners

The community health needs assessment (CHNA) was made possible through the leadership of San Gorgonio Memorial Hospital in Banning, California. Led by Holly Yonemoto, MBA who collaborated with Laura Acosta of HC2 Strategies, Inc.; Susan Harrington, MS, RD, and Karen Ochoa, MA, of Communities Lifting Communities. HC2 Strategies, Inc. conducted key informant

interviews, focus groups, and facilitated a prioritization process to identify the priority health needs for the 2019-2022 community health needs cycle.

Community Voices

A CHNA would not be complete without hearing from the local community. Those chosen to provide input represent the diversity of our community and those who are medically underserved, low-income, and minority populations. From June 14, 2019 to August 16, 2019 multiple focus groups, key informant interviews, and surveys were administered. A total of 151 people were surveyed to obtain input from the community in the form of 3 focus groups (with a total of 33 focus group participants), 10 key informant interviews, and 108 people who responded to the online survey (including a Spanish option). A description of each is described below.

Focus Groups

Focus group participants were residents who live in the San Gorgonio area in cities such as Banning, Beaumont, and Yucaipa who utilize various services offered in the county. The focus groups were representative of the general community, including populations who are low-income, seniors, and minority groups.

Key Informant Interviews

Key informant interviews consisted of key leaders in our community from an array of agencies, including those that represented public health departments, businesses, non-profits, and mental and behavioral health. Among the key leaders were organization board members, CEO's, directors, financial services officers, physicians, and program and property managers who serve the Inland Empire community, encompassing Riverside and San Bernardino Counties. A majority of the organizations provide services to vulnerable populations including veterans, low-income, at-risk, homeless, and LGBTQ communities.

Survey

Individuals who participated in the survey shared similarities with people who participated in the key informant interviews and focus groups. The majority of the survey respondents lived in Riverside County (87%), and only 13% reported living in a different county. Participants were from various cities across Riverside County including zip codes 92220, 92223, 92229, 92230, 92262, 92320, 92324, 92346, 92354, 92373, 92374, 92399, 92506, 92543, 92544, 92545, 92555, 92567, 92570, 92582, 92583, and 92220.

Our main objective in engaging the community was to discover strategies in which our hospital could collaborate to better serve communities and elevate the health status of our region. To better understand the needs, the focus groups and key informant interviews concentrated on these themes: Visions of a Healthy Community, Health Needs, Existing Resources, Barriers to Accessing Resources and Addressing Needs, Methods of Hospital Improvement and any additional feedback.

2019 Identified Priority Needs – Addressing Needs

Priority Need 1: Prevention & Management of Chronic Disease

- Diabetes
- Obesity
- Asthma
- Heart Disease
- Cancer
- Nutrition & Physical Activity

Goal: To increase the community's knowledge and management of chronic disease to reduce the incidence of chronic disease in our community.

Objectives

- Improve health indicators of program participants thru education.
- Improve health indicators thru increased health condition activities and access to resources.

Strategies	Baseline Measures	Short Term Measures	Outcome Measures
Diabetes: Adult Classes	# of participants # of classes	Increase education and management of diabetes	BMI % decrease
Diabetes: Child Classes Strong Life	# of participants # of classes	Increase education and management of diabetes	BMI % decrease
Diabetes: Tiered Weight Management	# of participants # of classes	Increase education and management of diabetes	BMI % decrease
Diabetes: Healthy Children Families Program	# of participants # of classes	Increase education and management of diabetes	BMI % decrease
Diabetes: Health Educator	# of participants	Increase education and management of diabetes	BMI % decrease
ALL chronic diseases: Farmers Market	# of weeks	Increase access to healthy foods and education	% increase in vendors and attendees

All Chronic diseases: Healthy Choices Cafeteria	# of individuals	Increase access to healthy foods and education	% increase in vendors and attendees
All Chronic: Healthy City Taskforce	# of times met	Increase access to healthy living options – exercise and diet	% increase of access of community resources
COPD: Post-Acute care Home Telehealth Monitoring	# of enrolled patient days	Increased # enrolled patient days	% decreased readmissions
Asthma & Bronchitis: ED antibiotic stewardship program	% of Bronchitis patients on antibiotics	Decreased antibiotic resistance	Increased efficacy of antibiotics

Priority Need 2: Access to Health Services

- Affordability/Insurance
- Transportation
- Shortage of Primary Care and Specialty Physicians

Goal: To increase access to quality, culturally competent healthcare to underinsured, uninsured and vulnerable in the community.

Objectives

- To increase transportation services for mental and behavioral healthcare.
- To strengthen healthcare professional training to positively impact the shortage of healthcare professionals.

Strategies	Baseline Measures	Short Term Measures	Outcome Measures
Afford/ insurance: Continue to provide assistance for Medi-Cal Eligibility	# of patients assisted # of encounters	Identify individuals in need of assistance	% increase and/or sustained in Medi-Cal and/or charity care eligibility
Mental Health Transportation Program	# of patients served; # of Encounters	Identify individuals that would benefit from the mental health transportation	% increase and/or sustained transportation utilization
Physician Assistant LLUH training program	# of students	Continue to provide a training site for respective students	% increase and/or sustained students rotating/training on site
Physician Assistant Western training program	# of students	Continue to provide a training site for respective students	% increase and/or sustained students rotating/training on site
Licensed Vocational Nurse training program Beaumont Adult School	# of students	Continue to provide a training site for respective students	% increase and/or sustained students rotating/training on site

Registered Nurse training program 3 colleges	# of students	Continue to provide a training site for respective students	% increase and/or sustained students rotating/training on site
Respiratory Therapy training program Crafton Hills College	# of students	Continue to provide a training site for respective students	% increase and/or sustained students rotating/training on site
Doctor of Pharmacy LLUH training program	# of students	Continue to provide a training site for respective students	% increase and/or sustained students rotating/training on site
ECHO Sonographer West Coast College	# of students	Continue to provide a training site for respective students	% increase and/or sustained students rotating/training on site
Radiology Technologist LLUH	# of students	Continue to provide a training site for respective students	% increase and/or sustained students rotating/training on site
Clinical Dietetic Interns LLUH	# of students	Continue to provide a training site for respective student	% increase and/or sustained students rotating/training on site

Priority Need 3 – Mental and Behavioral Health

- Intensive Outpatient Program
- Substance Abuse

Goal: To increase community's knowledge and ability to manage their disease.

Objectives

- Educate patients on coping mechanisms to manage their mental and behavioral health.
- Educate patients on the benefits of medical management of opioid addiction.

Strategies	Baseline Measures	Short Term Measures	Outcome Measures
Intensive Outpatient Program	# of patients served # of encounters	Identify individuals that would benefit from the mental health intervention/ treatment	% increase program utilization
Opioid Use Mitigation	# of patients served # of encounters	Identify individuals that would benefit from the intervention/ treatment	% increase program utilization

Identified Need from CHNA, Not Addressed

Taking existing hospital and community resources into consideration, San Gorgonio Memorial Hospital will not directly address the remaining health needs identified in the CHNA including: Affordable Housing and Homelessness. The hospital cannot address all the health needs present in the community; therefore, it will concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. SGMH will look for partnership opportunities that address needs not selected where it can appropriately contribute to addressing those needs, or where those needs align with current strategy and priorities.

Making a Difference: Evaluation of 2016 CHA

San Gorgonio Memorial Hospital has been involved in many activities to further the 2016 initiatives both hospital specific as well as regionally. SGMH is a member of the Hospital Association of Southern California (HASC) and was involved in the 2016 regional Community Health Needs Assessment.

The Hospital Association of Southern California (HASC) Inland Region office represents hospitals in Riverside and San Bernardino counties. Member hospitals are representative of many types of facilities, from rural to large teaching facilities, investor-owned to not-for-profit, VA to behavioral health, and community to public and district operated. HASC Inland Region office convenes and collaborates with member hospitals, local public health departments and community stakeholders to share current health issues and concerns in the region.

HASC Inland Region committees include:

- California Department of Public Health/Hospital Roundtable
- Homeless Patient Discharge Planning
- Workplace Violence Prevention Committee
- Behavioral Health Services Committee
- Emergency Health Services Committee
- Continuum of Care Committee
- HASC Accountable Communities for Health Initiative
- Workforce Development

In 2016 HASC Inland Region office coordinated the region's first Regional Community Health Needs Assessment (CHNA) in collaboration with 11 local hospitals. The assessment provided a detailed review of health in the Inland Empire with clear similarities and variability across the two counties and hospital service areas and SGMH was one of the participating hospitals. The top chronic health conditions expressed through data compilation included (in alphabetical order):

- Asthma & Bronchitis
- Chronic Obstructive Pulmonary Disease
- Diabetes
- Mental Illness
- Obesity
- Substance Abuse

During the regional prioritization process, the Inland Empire Regional CHNA Taskforce decided that as a region they will focus on Diabetes, Obesity and Workforce Development as their health priorities. Specifically, SGMH addressed Diabetes, Obesity and Workforce Development as follows:

Diabetes/Obesity

Obesity is the greatest risk factor in developing type II diabetes. In response to the growing obesity epidemic and needs of the community, SGMH has implemented and engaged in many initiatives. These initiatives are described below and reflect the commitment that San Gorgonio Memorial Hospital has to the community and to the region.

Adult & Child Health Classes

SGMH offers both free nutrition classes and individual counseling by a registered dietitian for those in the Medi-Cal population with a BMI of greater than 25 (with a physician referral). Adult classes have four sessions that address label reading, food budgeting, exercise, weight loss, and changing habits. Individual sessions focus on health goal setting and weight loss techniques. This includes education on blood sugar goals, carbohydrate metabolism, weight loss techniques, and goal setting for long term success. Adults are recruited from local physician referral, community outreach, and Inland Empire Health Plan's internet site. Food tasting/cooking classes for children are also offered, educating families on healthy food choices and the benefits of physical activity. The children are recruited from local physician offices, WIC clinics, school districts, and community outreach.

Tiered Weight Management Program & Healthy Children and Families Program

In 2016, SGMH began the infrastructure building for a Tiered Weight Management Program as well as a Healthy Children and Families Program. Since inception, these programs have blossomed and touched the lives of hundreds of patients and community members. These programs are held in a group setting and include initial weight counseling, lifestyle education, and collaborative cooking/healthy eating classes. We have had great interest in our adult cooking/healthful eating series. In addition to the group setting, referring physicians are sending obese diabetics to our 1:1 sessions with a resultant decrease in need for medications. Physician-referred children have been very receptive to the fruit and vegetable tasting class as well. Parents have reported adding more fruits and vegetables to their diets as a result of the series. We recently added a low sodium cooking series focused on our community's heart failure clients.

Health Educator for IEHP and Strong4Life Program

SGMH has also been approved as a listed health educator for IEHP in 2019 and this has been a large success to date. They are now offering our adult classes on their web site and have informed local providers of the service. An increase in participation since June of 2019 has been seen. IEHP also incentivizes their clients to attend the workshops.

Often, parents who attend this workshop will in turn bring their children to the Strong4Life program at SGMH.

Farmers Market

In 2017, SGMH was in discussions with Riverside University Health System (RUHS)Public Health Department to potentially open a farmers market onsite. In turn, we collaborated with the Nutrition Education and Obesity Prevention Program (NEOP) and with Cal Fresh/Market Match, designing a successful farmers market for our community. This vision came to fruition as we hosted the grand opening of our Certified Farmers Market in March of 2019.

Health Information & Classes by Registered Dietitian — Weight Management Certified

Within SGMH, at a more local level, the lead registered dietitian recently received her Certificate of Training in Adult Weight Management through the Academy of Nutrition and Dietetics. This specialty certification has provided valuable knowledge, great networking, and learning opportunities which she has been able to pass on and share with our clientele and our local community through important health information and classes.

Recognized Healthy Choices Cafeteria

The on-site SGMH cafeteria, which is also open to the community, has been recognized for the efforts they have actively pursued in the mission of making health eating choices easy and affordable to employees and the community. One of the many healthy eating choice improvements that have been implemented since 2016 has been the free infused water, which remains very popular. Additionally, the cafeteria offers a variety of pieces of fresh fruit at a discounted price with hopes of enticing heathy snack habits to the community and visitor population as well as employees.

Many customers add fruit simply because of the low cost. A recent initiative includes implementing Adult Wellness Meals at a cost of $5.00 for both employees and visitors, hoping the reduced cost to visitors will enhance purchases for the complete meal and continue make a difference in the health of the community one person and one meal at a time. Offering healthier choices since 2016 has resulted in dramatically decreased consumption of sugar-based drinks and fat laden foods and will continue to make an immediate difference in our community

Nutrition Education and Obesity Prevention Program & Health City Taskforce

SGMH has developed a partnership with the Nutrition Education and Obesity Prevention (NEOP) program, which has provided the hospital with connections to Banning's Women Infant Child (WIC) facility and the California State preschool and summer lunch programs. At those sites, SGMH has begun nutrition education and has invited participants to attend SGMH's Strong4Life workshops. This has generated high interest,

and since June of 2019 attendance has increased. SGMH continues to work with the Healthy City Taskforce and regularly participates in local events promoting health.

Workforce Development

San Gorgonio Memorial Hospital has had an ongoing commitment to healthcare education in the region. The healthcare education initiatives at SGMH have been to support both the community and the community health needs assessment priorities. We support a significant number of programs by providing the clinical sites and preceptors, along with supporting continuing education for SGMH employees. SGMH continues to look for additional educational collaboration opportunities, in addition to the list below, such as potential residency programs at SGMH.

San Gorgonio Memorial Hospital has been involved in the educational development of hundreds of healthcare students over the years.

Student programs in which we provide clinical sites/hours/preceptors for multiple schools:

- Physician Assistants (Experiential site for Loma Linda University students)
- Physician Assistants (Experiential site for Western University students)
- Licensed Vocational Nurse (LV) (Beaumont Adult School)
- Registered Nurse (RN) (Mt. San Jacinto College, San Bernardino Valley College, College of the Desert)
- Respiratory Therapy – clinical site, as well as, mentorship program including mock interviews prior to graduation (Crafton Hills College)
- Doctor of Pharmacy (Pharm D) (Experiential site — responsible for the Introductory and Advanced Pharmacy Practice Experience for Loma Linda University School of Pharmacy students)
- ECHO Sonography (West Coast Ultrasound)
- Ultrasound (Mt. San Jacinto College)
- Radiology Technologist (Loma Linda University)
- Clinical Dietetic Interns (Patton State Hospital, Loma Linda University)

Strategic Partner List

In an effort to better understand our community assets, SGMH was tasked with exploring current and desired partnerships and compiling a list of community resources dedicated to the health and well-being of the community. Partnership is not used as a legal term, but a description of the relationships of connectivity that are necessary to collectively improve the health of our region. One of our objectives is to partner with organizations that share our values and priorities to improve the health status and quality of life of the community we serve. This is an intentional effort to avoid duplication and leverage the successful work already in existence in the community. Many important systemic efforts are underway in our region, and we have been in partnership with multiple not-for-profits to provide quality care to the underserved in our region. The following list is not intended to be exhaustive, but rather representative of organizations that offer services in Riverside County. Identified resources are as follows:

- 211 Community Connect, Riverside County
- American Cancer Society
- Arrowhead Regional Medical Center
- Beaumont Unified School District
- Boys & Girls Clubs of Pass
- Building A Generation
- City of Redlands, Police and Recreation Departments
- Dignity Health — St. Bernardine Medical Center
- Inland Empire Community Benefit Collaborative
- Healthy Cities
- LifeStream Blood Bank
- Loma Linda University Health System
- Mercy Air Helicopter Service
- REACH
- Family Service Association of Redlands
- Redlands Unified School District
- Riverside, 211 United Way
- Rotary Club of San Gorgonio Pass
- Riverside Community Hospital
- Riverside County Fire Department
- Riverside County Paramedics

Financial Assistance Policies

Policy: SELF PAY DISCOUNTS

It is the policy of San Gorgonio Memorial Hospital to offer self pay discounts for uninsured patients, underinsured patients, or for patients needing service not otherwise covered by an insurance company. All Self-pay patients who do have an ability to pay and whose income exceeds 350% of the Federal Poverty Level (FPL) will receive the standard self pay discount. Note: All Self-pay patients whose documented income falls below 350% FPL can be considered for Charity Care.

For full policy please go to sgmh.org/self-pay-policy/

Policy: CHARITY CARE

Whenever it becomes apparent that the patient may have difficulty in meeting their financial responsibility to the hospital, the patient will be requested to complete the application process for Covered CA, California Medi-cal, presumptive Medi-cal and/or any other available programs. In accordance with SB 1276 and AB774 which expands the availability of charity care and discount program and payment plans to all patients with high medical costs, pending applications for health insurance coverage does not preclude the patient from being eligible for the hospital's charity care or discount payment program.

For full policy please contact us at sgmh.org

Approval

This Implementation Strategy Report was approved on XX by the San Gorgonio Memorial Hospital Board of Directors. The final report was made widely available on XX.

____

Susan Dibiassi Date
SGMH Board Chair

PENDING APPROVAL

600 N Highland Springs Ave.

Banning, CA 92220

TAB J

April 29, 2020

Foundation Finances as of 4/29/2020

- $427,083.22 (Bank of Hemet Business checking account) as of 04/29/2020
- $127,565.12 (Bank of Hemet Money market account) as of 04/29/2020
- $62,942.21 (I.E. Community Foundation as of 04/29/2020) ♣
- $617,590.55 Total Funds

♣ $200K moved to Bank of Hemet Checking account to fulfill a$200K commitment to pay for Ventilators and PPE

Foundation News – Community Outreach –

- The COVID19 RESPONSE FUND was announced in the Record Gazette as of 4/3/2020. As of 4/29/2020 the COVID19 RESPONSE FUND has almost $51,000.00 which includes a $30K donation from SGMH Foundation to specifically pay for PPE's.
- SGMH Foundation board voted to pay for (6) ventilators for the hospital with a donation of $170K and$30K designated for PPE (of which $30K is now in the COVID19 RESPONSE FUND).
- The residents within our service area have been very generous with In-kind donations from the community. Such as: Homemade masks, shoe covers, homemade face shield masks, gloves, CPAP machines, a BIPAP machine and lots and lots of food!!
- With the cancelation of the Gala due to Covid19, here is the new breakdown for the Gala:
  Gala Comparison - 2019 Gala vs 2020 Gala

Morongo Casino Resort &Spa Sat Mar 14, 2020			
Perfect Partner - Bank of Hemet			
Tribute to Veterans - CANCELED-COVID19			
REVENUE breakdown 2020	2020 ACTUAL	***REVENUE breakdown 2019***	2019 ACTUAL
Individual Ticket sales, Sponsorship & Donations Total Gross Revenue	$ 56,588.00	Individual Ticket sales, Sponsorship, Hospital Challenge, silent auction, centerpiece sales & cruise ticket sales Total Gross Revenue	$117,520.00
Total Expenses	$ 6,971.77	Total Expenses	$ 61,933.04
NET REVENUE	$49,491.23	NET REVENUE	$55,586.96
2020 TOTAL REFUNDS	$ 1,600.00		
2020 PLEDGED BUT NO PYMNT RECVD	$ 12,450.00		
2020 Changed mind. Wants their $ to support COVID19 RESPONSE FUND	$ 4,725.00		
	$ 18,775.00		

TAB K

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

FINANCE COMMITTEE
Tuesday, April 28, 2020

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors Finance Committee was held on Tuesday, April 28, 2020. In an effort to prevent the spread of COVID-19 (coronavirus), and in accordance with the Governor's Executive Order N-29-20, there was no public location for attending this committee meeting in person. Committee members, staff members, and members of the public participated telephonically.

Due to technical difficulties in establishing call in connections, this meeting did not occur.

San Gorgonio Memorial Hospital
Financial Report – Executive Summary

For the month of March 2020 (Nine months in FY 20)

Concluding Summary

Earnings before interest, depreciation and amortization (EBIDA) VARIANCES:

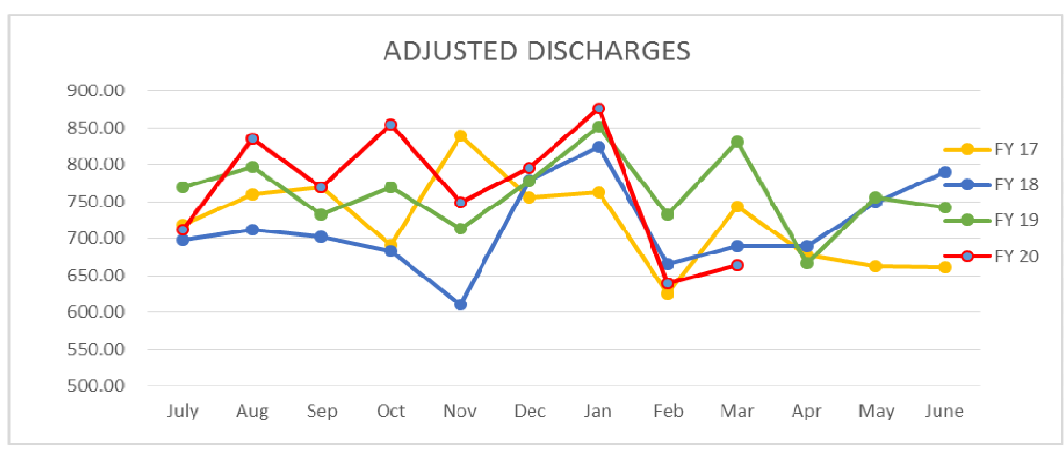
For the Month:	Actual missed Budget by	- **$832,000**
Year-to- Date (9 mo.):	Actual exceeded Budget by	**$852,000**
Versus PRIOR YTD	FY 20 exceeded FY 19 by	**$21,000**

Positive takeaways for the month:

1) Finalizing new anesthesia agreement
2) Improved (higher) line of credit with Bank approval
3) Improved (reduced) accounts payable balances

Negative takeaways for the month:

1) Cash flow challenges due timing of supplemental payments resulting in higher LOC balances. (Balances owed up to $12.0 Max end of March)
2) Higher expenses especially anesthesia.



Prepared 4/29/2020
Dave Recupero, CFO

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA

Unaudited Financial Statements

for

NINE MONTHs ENDING MAR 31, 2020

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements, except for the uncertainty of IGT revenue accruals, do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respsects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

David D. Recupero

CFO

San Gorgonio Memorial Hospital
Financial Report – Executive Summary
For the month of March 2020 (Nine months in FY 20)

Profit/Loss (EBIDA) Summary
In the current month, there was a $832K unfavorable budget variance in Earnings before Interest, Depreciation and Amortization (EBIDA). March EBIDA actual was -$567K, or a -17.1% EBIDA margin. The resulting Year-to-Date (YTD) EBIDA budget variance was $941K or $852K over budget. YTD Actual FY 20 EBIDA compared to prior year FY19 was $20K improved. Year-to-Date increase/decrease in unrestricted net assets (net profit) was $2.025M loss compared to the budgeted YTD loss of $2.43M and last year's YTD loss of $1.94M.

Analysis
About half way thru the month we saw a dramatic falloff of patient volumes and revenues due covid -19 virus government shut down of non-essential services. Besides elective surgeries falloff we saw a precipitous drop in ED visits and ED admits. For the month ED visits were 19.7% below budget and ED admits were 30.4% below budget. We have seen a trend of reduced non-covid acute patients not coming to the ED resulting in non-virus related admissions to be down significantly. Volumes as measured by gross charges for the month were 28% below budget over-all but 41.7% below budget on the inpatient side. Net revenues were $1.32 million below budget for the month. The resulting unfavorable $832K EBIDA variance was partially mitigated by actual operating expenses for the month coming in $510K below budget or 7.7%. For the year. Net Patient revenues of $36.5M was $991K less than budget but $1.16 million improved over the FY 19 Year-to-Date figure. Operating expenses YTD were 2.1% over budget.

Net Patient Revenues (unfavorable $1.3M) or 28.9% .The net figure came in consistent with the 28.54% gross revenue variance, however will likely be adjusted higher due to the significant increase in this month's Medicare case mix index (CMI) of 1.4780 vs 1.2621 budget. The higher the index the more complex cases we had resulting in improved projected reimbursement. Also encouraging was a lower average length of stay 3.06 vs 3.91 budget. Next month we will be adding a more sophisticated projection for IP Medicare payments (instead of using the historical % of charges). This will likely improve EBIDA by $50-100K. due to the key statistics reflecting a less cost per discharge to go along with the higher case mix and payment rates. Year-to-Date net patient revenues are tracking slightly behind budget at -2.64%

Total Operating Revenues (unfavorable $1.3M) . Supplemental revenues for the month came in very close to budget .Total Operating revenue which includes IGTs shows a $2.027M year-to-date favorable variance. It is important to note that thru March we have not recorded any Federal Cares Act Hospital Stimulus funds nor Medicare Advance payments. Early April we received a loan Medicare advance of $2.5 million and a federal grant of $657,000 for virus relief from the Cares Act. We have been told that we can expect future Cares Act funding for hospitals. Also worth noting that the $18.0 million IGT (rate range) payments are still forthcoming and expected in late April or early May.
Key patient statistics variances included:
Average Daily Census (ADC) in March (19.9 actual vs 36.1 budget and 33.9 last year). YTD
.

ADC actual= 24.8 vs budget 28.4 and last year first 9 months ADC was 26.7. YTD ED visits were 84% below budget. Inpatient acute days for the month were 44.9 % below budget. Areas of declined patient activity include observation bed days (down 14.05% YTD) and outpatient surgeries (down 38.6% YTD). The over-all measurement of patient activity adjusted acute discharges were down 6.26% compared to budget and 0.98% lower compared to last year.

In summary, the $3.0 million YTD favorable supplemental revenues explains the health system's year-to-date favorable YTD EBIDA variance.

Expenses (unfavorable $483K) lower than budgeted training cost and purchased services caused expense to be below budget in the month. The higher physician fees category is likely to near its end with a new Beaver anesthesia contract ready for your approval this month. Legal fees were 20K below budget for the month and $139K below budget for the year.

BALANCE SHEET/CASH FLOW

Cash Balances continued lower (as expected) due to low supplemental funding. The 4 week delay in processing our new line of credit also affected our accounts payable balances going to over $7.5 million last month fell to $6.4 million in March. As of April 8, however, a portion of the supplemental funds have come in and AP is down to normal levels.

The FY 20 fiscal year-end projected cash now showing lower projections (several million) to the original budgeted estimates due to the projected virus volume impact. There remains hope that future stimulus payment amounts before year-end could bring the year-end projections back in line with budget.

Concluding Summary

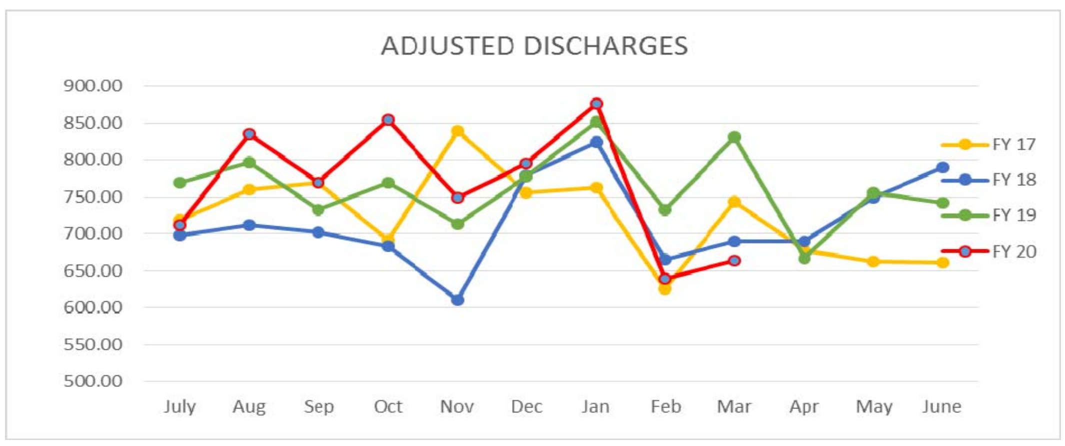
Positive takeaways for the month:

1) Finalized new anesthesia agreement.
2) Improved line of credit now in place for the next 2 years.
3) Vastly Improved IGT projections (+$3.0 million) due to several miscellaneous adjustments (updated 18-19 rate range; 19-20 rate range IGT; and HQAF6 Direct Grant IGT)

Negative takeaways for the month:

1) Cash flow challenges as anticipated mostly due timing issues with IGTs and slower processing of new LOC.
2) Higher than expected physician fees especially related to anesthesia costs.

Prepared 04/20/2020
Dave Recupero, CFO



Statement of Revenue and Expense

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
NINE MONTHs ENDING MAR 31, 2020

	DISTRICT ONLY	CURRENT MONTH				
		COMBINED		Positive		Prior
	Actual	Actual	Budget	(Negative)	Percentage	Year
	03/31/20	03/31/20	03/31/20	Variance	Variance	03/31/19
Gross Patient Revenue						
[1] Inpatient Revenue	$0	$5,898,235	$10,117,613	($4,219,378)	-41.70%	$9,738,857
[2] Inpatient Psych/Rehab Revenue	0	0	0	0	0.00%	0
[3] Outpatient Revenue	0	13,587,971	17,152,631	(3,564,660)	-20.78%	18,288,433
[4] Long Term Care Revenue	0	0	0	0	0.00%	0
[5] Home Health Revenue	0	0	0	0	0.00%	0
[6] Total Gross Patient Revenue	0	19,486,206	27,270,244	(7,784,038)	-28.54%	28,027,291
Deductions From Revenue						
[7] Discounts and Allowances	0	(15,440,332)	(21,672,327)	6,231,995	28.76%	(22,039,411)
[8] Bad Debt Expense	0	(752,788)	(913,966)	161,178	17.64%	(1,148,393)
[9] Prior Year Settlements	0	0	(62,522)	62,522	100.00%	0
[10] Charity Care	0	(45,993)	(53,621)	7,628	14.23%	(42,008)
[11] Total Deductions From Revenue	0	(16,239,112)	(22,702,436)	6,463,324	28.47%	(23,229,812)
[12]		83.34%	83.25%			82.88%
[13] Net Patient Revenue	0	3,247,093	4,567,808	(1,320,715)	-28.91%	4,797,479
Non Patient Operating Revenues						
[14] IGT/DSH Revenues	0	1,740,766	1,600,000	140,766	8.80%	1,297,769
[15] Tax Subsidies Measure D	188,750	188,750	259,027	(70,277)	-27.13%	175,000
[16] Tax Subsidies Prop 13	112,500	112,500	155,650	(43,150)	-27.72%	105,000
[17] Tax Subsidies County Supplemental Funds	4,558	4,558.22	0	4,558	0.00%	0
[18] Other Operating Revenue	581	236,056	280,908	(44,852)	-15.97%	320,492
[19] Clinic Net Revenues	18,887	18,887	27,753	(8,866)	-31.95%	23,449
Non- Patient Revenue	325,276	2,301,517	2,323,338	(21,821)	-0.94%	1,921,711
Total Operating Revenue	**325,276**	**5,548,610**	**6,891,146**	**(1,342,536)**	**-19.48%**	**6,719,189**
Operating Expenses						
[20] Salaries and Wages	0	3,163,165	3,218,350	55,185	1.71%	3,019,653
[21] Fringe Benefits	0	709,902	729,688	19,787	2.71%	486,094
[22] Contract Labor	0	59,030	55,579	(3,451)	-6.21%	111,857
[23] Physicians Fees	0	420,336	195,484	(224,852)	-115.02%	310,885
[24] Purchased Services	26,006	507,926	767,761	259,835	33.84%	502,166
[25] Supply Expense	45	750,940	850,574	99,634	11.71%	916,494
[26] Utilities	0	87,394	71,386	(16,008)	-22.42%	65,525
[27] Repairs and Maintenance	0	55,186	45,038	(10,148)	-22.53%	43,345
[28] Insurance Expense	0	84,799	101,452	16,653	16.42%	70,407
[29] All Other Operating Expenses	4,059	144,485	422,680	278,196	65.82%	236,277
[30] IGT Expense	0	46	0	(46)	0.00%	0
[31] Leases and Rentals	0	49,933	68,143	18,210	26.72%	130,232
[32] Clinic Expense	57,564	82,477	99,817	17,340	17.37%	99,177
[33] **Total Operating Expenses**	**87,674**	**6,115,618**	**6,625,953**	**510,335**	**7.70%**	**5,992,110**
[34] **EBIDA**	**237,602**	**(567,008)**	**265,193**	**(832,201)**	**-313.81%**	**727,079**
Interest Expense and Depreciation						
[35] Depreciation	502,454	502,454	500,000	(2,454)	-0.49%	494,513
[36] Interest Expense and Amortization	389,399	606,913	399,474	(207,439)	-51.93%	397,709
[37] **Total Interest & depreciation**	891,853	1,109,367	899,474	(209,893)	-23.34%	892,222
Non-Operating Revenue:						
[38] Contributions & Other	0	0	16,667	(16,667)	-100.00%	32,439
[39] Tax Subsidies for GO Bonds - M-A	598,629	598,629	605,781	(7,152)	-1.18%	585,613
[40] **Total Non Operating Revenue/(Expense)**	**598,629**	**598,629**	**622,448**	**(23,819)**	**-3.83%**	**618,052**
[41] **Total Net Surplus/(Loss)**	**($55,622)**	**($1,077,746)**	**($11,833)**	**($1,065,913)**	**9007.85%**	**$452,909**
[42] Extra-ordinary loss on FInancing						
[43] **Increase/(Decrease in Unrestricted Net Assets**	**($55,622)**	**($1,077,746)**	**($11,833)**	**($1,065,913)**	**9007.85%**	**$452,909**
[44] **Total Profit Margin**	**-17.10%**	**-19.42%**	**-0.17%**			**6.74%**
[45] **EBIDA %**	**73.05%**	**-10.22%**	**3.85%**			**10.82%**

Statement of Revenue and Expense

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
NINE MONTHs ENDING MAR 31, 2020

	DISTRICT ONLY Actual 03/31/20	YEAR-TO-DATE Actual 03/31/20	Budget 03/31/20	Positive (Negative) Variance	Percentage Variance	Prior Year 03/31/19
Gross Patient Revenue						
[1] Inpatient Revenue	$0	$64,010,371	$70,659,785	($6,649,414)	-9.41%	$67,367,119
[2] Inpatient Psych/Rehab Revenue	0	0	0	0	0.00%	0
[3] Outpatient Revenue	0	149,634,032	154,931,823	(5,297,791)	-3.42%	149,925,576
[4] Long Term Care Revenue	0	0	0	0	0.00%	0
[5] Home Health Revenue	0	0	0	0	0.00%	0
[6] Total Gross Patient Revenue	0	213,644,402	225,591,608	(11,947,206)	-5.30%	217,292,696
Deductions From Revenue						
[7] Discounts and Allowances	0	(170,046,550)	(179,537,631)	9,491,081	5.29%	(174,139,251)
[8] Bad Debt Expense	0	(6,409,365)	(7,560,732)	1,151,367	15.23%	(7,367,073)
[9] Prior Year Settlements	0	0	(517,212)	517,212	100.00%	0
[10] Charity Care	0	(647,193)	(443,574)	(203,619)	-45.90%	(405,099)
[11] Total Deductions From Revenue	0	(177,103,108)	(188,059,149)	10,956,041	5.83%	(181,911,423)
[12]		82.9%	83.4%	-0.5%		83.7%
[13] Net Patient Revenue	0	36,541,295	37,532,459	(991,164)	-2.64%	35,381,273
Non Patient Operating Revenues						
[14] IGT/DSH Revenues	0	14,831,090	11,600,000	3,231,090	27.85%	10,934,126
[15] Tax Subsidies Measure D	1,827,377	1,827,377	1,809,006	18,371	1.02%	1,675,000
[16] Tax Subsidies Prop 13	1,031,231	1,031,231	1,087,034	(55,803)	-5.13%	945,000
[17] Tax Subsidies County Supplemental Funds	108,739	108,739	97,500	11,239	11.53%	96,957
[18] Other Operating Revenue	33,462	2,132,224	2,256,748	(124,524)	-5.52%	2,055,429
[19] Clinic Net Revenues	188,111	188,111	249,777	(61,666)	-24.69%	219,655
Non- Patient Revenue	3,188,920	20,118,771	17,100,065	3,018,706	17.65%	15,926,167
Total Operating Revenue	**3,188,920**	**56,660,066**	**54,632,524**	**2,027,542**	**3.71%**	**51,307,440**
Operating Expenses						
[20] Salaries and Wages	0	28,268,149	27,585,406	(682,743)	-2.48%	25,702,703
[21] Fringe Benefits	0	6,515,707	6,611,839	96,132	1.45%	6,332,420
[22] Contract Labor	0	616,411	500,211	(116,200)	-23.23%	838,893
[23] Physicians Fees	8,800	2,968,231	1,759,356	(1,208,875)	-68.71%	2,167,973
[24] Purchased Services	387,714	5,842,353	6,255,603	413,250	6.61%	3,769,864
[25] Supply Expense	554	6,581,606	6,542,847	(38,759)	-0.59%	6,115,806
[26] Utilities	3,000	719,285	642,474	(76,811)	-11.96%	685,844
[27] Repairs and Maintenance	6,475	499,876	405,342	(94,534)	-23.32%	449,379
[28] Insurance Expense	0	810,860	913,068	102,208	11.19%	832,823
[29] All Other Operating Expenses	64,845	1,410,461	1,816,736	406,275	22.36%	1,323,470
[30] IGT Expense	0	(109)	0	109	0.00%	0
[31] Leases and Rentals	0	651,963	613,287	(38,676)	-6.31%	1,240,512
[32] Clinic Expense	599,711	834,592	898,353	63,761	7.10%	927,690
[33] **Total Operating Expenses**	**1,071,098**	**55,719,386**	**54,544,522**	**(1,174,864)**	**-2.15%**	**50,387,376**
[34] **EBIDA**	**2,117,822**	**940,681**	**88,002**	**852,678**	**968.93%**	**920,064**
Interest Expense and Depreciation						
[35] Depreciation	4,514,146	4,514,146	4,526,000	11,854	0.26%	4,523,691
[36] Interest Expense and Amortization	3,509,338	3,885,428	3,595,266	(290,162)	-8.07%	3,688,466
[37] **Total Interest & depreciation**	8,023,484	8,399,573	8,121,266	(278,307)	-3.43%	8,212,158
Non-Operating Revenue:						
[38] Contributions & Other	163,194	163,194	150,003	13,191	8.79%	82,964
[39] Tax Subsidies for GO Bonds - M-A	5,270,465	5,270,465	5,452,029	(181,564)	-3.33%	5,270,513
[40] **Total Non Operating Revenue/(Expen**	**5,433,658**	**5,433,658**	**5,602,032**	**(168,374)**	**-3.01%**	**5,353,476**
[41] **Total Net Surplus/(Loss)**	**($472,003)**	**($2,025,234)**	**($2,431,232)**	**$405,997**	**-16.70%**	**($1,938,617)**
[42] Extra-ordinary loss on FInancing						
[43] **Increase/(Decrease in Unrestricted Net /**	**($472,003)**	**($2,025,234)**	**($2,431,232)**	**$405,997**	**-16.70%**	**($1,938,617)**
[44] **Total Profit Margin**	**-14.80%**	**-3.57%**	**-4.45%**			**-3.78%**
[45] **EBIDA %**	**66.41%**	**1.66%**	**0.16%**			**1.79%**

Balance Sheet - Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
NINE MONTHs ENDING MAR 31, 2020

				ASSETS		
Percent of Net AR to Gross AR>	DISTRICT ONLY	18.19%	18.26%	Curr vs Prior Mo.	17.33%	Curr vs Prior YE
	Current Month 03/31/2020	Current Month 03/31/2020	Prior Month 02/29/2020	Positive/ (Negative) Variance	Prior Year End 06/30/2019	Positive/ (Negative) Variance
Current Assets						
[1] Cash and Cash Equivalents	$2,340,154	$2,748,844	$2,034,657	$714,187	$4,175,227	($1,426,383)
[2] Gross Patient Accounts Receivable	0	45,836,716	51,832,850	(5,996,134)	49,210,703	(3,373,987)
[3] Less: Bad Debt and Allowance Reserves	0	(37,501,114)	(42,369,443)	4,868,329	(40,680,940)	3,179,827
[4] Net Patient Accounts Receivable	0	8,335,602	9,463,407	(1,127,804)	8,529,763	(194,160)
[5] Taxes Receivable	2,493,211	2,493,211	2,422,094	71,116	566,680	1,926,531
[6] Other Receivables	0	615,113	501,394	113,720	436,869	178,244
[7] Inventories	0	1,671,529	1,709,861	(38,331)	1,632,865	38,664
[8] Prepaid Expenses	72,875	393,087	400,206	(7,119)	1,326,928	(933,841)
[9] Due From Third Party Payers	0	1,099,000	1,138,607	(39,607)	554,344	544,656
[10] Malpractice Receivable	0	0	0	0	0	0
[11] IGT Receivables	0	23,468,257	22,311,121	1,157,137	10,058,792	13,409,465
Total Current Assets	**4,906,240**	**40,824,644**	**39,981,346**	**843,298**	**27,281,468**	**13,543,176**
Assets Whose Use is Limited						
[12] Cash	0	0	0	0	0	0
[13] Investments	0	0	0	0	0	0
[14] Bond Reserve/Debt Retirement Fund	6,910,006	6,914,951	6,608,925	306,025	8,867,208	(1,952,257)
[15] Trustee Held Funds	0	0	0	0	0	0
[16] Funded Depreciation	0	0	0	0	0	0
[17] Board Designated Funds	0	0	0	0	0	0
[18] Other Limited Use Assets	0	0	0	0	0	0
Total Limited Use Assets	**6,910,006**	**6,914,951**	**6,608,925**	**306,025**	**8,867,208**	**(1,952,257)**
Property, Plant, and Equipment						
[19] Land and Land Improvements	6,686,845	6,686,845	6,686,845	0	4,820,671	1,866,174
[20] Building and Building Improvements	127,399,218	127,399,218	127,399,218	0	129,283,884	(1,884,666)
[21] Equipment	26,124,826	26,124,826	26,098,248	26,579	25,586,875	537,951
[22] Construction In Progress	8,391,329	8,391,329	8,391,329	0	8,390,249	1,080
[23] Capitalized Interest	0	0	0	0	0	0
[24] Gross Property, Plant, and Equipment	168,602,218	168,602,218	168,575,639	26,579	168,081,679	520,539
[25] Less: Accumulated Depreciation	(75,595,360)	(75,595,360)	(75,092,906)	(502,454)	(71,114,751)	(4,480,609)
[26] **Net Property, Plant, and Equipment**	**93,006,859**	**93,006,859**	**93,482,734**	**(475,875)**	**96,966,928**	**(3,960,069)**
Other Assets						
[27] Unamortized Loan Costs	1,454,654	1,454,654	1,456,314	(1,660)	1,522,444	(67,790)
[28] Assets Held for Future Use	0	0	0	0	0	0
[29] Investments in Subsidiary/Affiliated Org.	12,117,551	0	0	0	0	0
[30] Other	0	0	0	0	0	0
[31] **Total Other Assets**	**13,572,206**	**1,454,654**	**1,456,314**	**(1,660)**	**1,522,444**	**(67,790)**
[32] **TOTAL UNRESTRICTED ASSETS**	**118,395,310**	**142,201,107**	**$141,529,319**	**$671,788**	**134,638,048**	**$7,563,059**
Restricted Assets	0	0	0	0	0	0
[33] **TOTAL ASSETS**	**$118,395,310**	**$142,201,107**	**$141,529,319**	**$671,788**	**$134,638,048**	**$7,563,059**

Balance Sheet - Liabilities and Net Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
NINE MONTHs ENDING MAR 31, 2020

	District Only	LIABILITIES AND FUND BALANCE				Curr vs Prior YE
	Current Month 03/31/2020	Current Month 03/31/2020	Prior Month 02/29/2020	Positive/ (Negative) Variance	Prior Year End 06/30/2019	Positive/ (Negative) Variance
Current Liabilities						
[1] Accounts Payable	$165,555	$6,393,698	$7,558,127	($1,164,429)	$4,436,438	$1,957,260
[2] Notes and Loans Payable (Line of Credit)	0	12,000,000	$10,000,000	2,000,000	$0	12,000,000
[3] Accounts Payable- Construction	0	0	$0	0	$0	0
[4] Accrued Payroll Taxes	0	3,470,339	$2,970,853	499,486	$3,844,094	(373,755)
[5] Accrued Benefits	0	77,916	$81,509	(3,593)	$76,513	1,404
[6] Accrued Benefits Current Portion	0	0	$0	0	$0	0
[7] Other Accrued Expenses	0	0	$0	0	$0	0
[8] Accrued GO Bond Interest Payable	808,092	808,092	$404,046	404,046	$2,049,304	(1,241,212)
[9] Malpractice Payable	0	0	$0	0	$0	0
[10] Due to Third Party Payers (Settlements)	0	0	$0	0	$0	0
[11] Advances From Third Party Payers	0	0	$0	0	$0	0
[12] Current Portion of LTD (Bonds/Mortgages)	2,335,000	2,335,000	$2,335,000	0	$0	2,335,000
[13] Current Portion of LTD (Leases)	0	0	$0	0	$0	0
[14] Other Current Liabilities	0	35,818	6,041	29,777	15,758	20,060
Total Current Liabilities	**3,308,647**	**25,120,863**	**23,355,576**	**1,765,287**	**10,422,106**	**14,698,757**
Long Term Debt						
[15] Bonds/Mortgages Payable (net of Cur Portio	108,261,081	108,261,081	108,276,833	(15,753)	112,856,547	(4,595,467)
[16] Leases Payable (net of current portion)	0	0	0	0	0	0
[17] **Total Long Term Debt (Net of Current)**	**108,261,081**	**108,261,081**	**108,276,833**	**(15,753)**	**112,856,547**	**(4,595,467)**
Other Long Term Liabilities						
[18] Deferred Revenue	0	0	0	0	0	0
[19] Accrued Pension Expense (Net of Current)	0	0	0	0	0	0
[20] Other	0	0	0	0	0	0
[21] **Total Other Long Term Liabilities**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL LIABILITIES	**111,569,727**	**133,381,943**	**131,632,409**	**1,749,534**	**123,278,653**	**10,103,290**
Net Assets:						
[22] Unrestricted Fund Balance	7,297,586	10,844,398	$10,844,398	0	10,416,645	427,754
[23] Temporarily Restricted Fund Balance	0	0	0	0	0	0
[24] Restricted Fund Balance	0	0	0	0	0	0
[25] Net Revenue/(Expenses)	(472,003)	(2,025,234)	(947,488)	(1,077,746)	942,750	(2,967,984)
[26] **TOTAL NET ASSETS**	**6,825,583**	**8,819,164**	**9,896,910**	**(1,077,746)**	**11,359,394**	**(2,540,231)**
[27] **TOTAL LIABILITIES AND NET ASSETS**	**$118,395,310**	**$142,201,107**	**$141,529,319**	**$671,788**	**$134,638,048**	**$7,563,059**
	$0	$0	$0.00		$0	

BANNING, CALIFORNIA
NINE MONTHs ENDING MAR 31, 2020

HEALTHCARE SYSTEM MINI CASH FLOW			CASH FLOW Current Month 03/31/2020		Year-To-Date 03/31/2020
	BEGINNING CASH BALANCES				
[1]	Cash: Beginning Balances- HOSPITAL	2/29	$154,860	06/30>	1,049,179.00
[2]	Cash: Beginning Balances- DISTRICT	2/29	1,879,797	06/30>	3,126,083
[3]	Cash: Beginning Balances TOTALS	2/29	$2,034,657	06/30>	$4,175,262
	Receipts				
[4]	Pt Collections		3,956,788		35,949,612
[5]	Tax Subsidies Measure D		0		1,505,581
[6]	Tax Subsidies Prop 13		0		738,858
[7]	Tax Subsidies County Supplemental Funds		4,558		108,739
[8]	IGT & other Supplemental (see detail below)		(201,261)		907,421
[9]	Draws/(Paydown) of LOC Balances		2,000,000		12,000,000
[10]	Other Misc Receipts/Transfers		254,943		2,320,334
	TOTAL RECEIPTS		**6,015,028**		**53,530,545**
	Disbursements				
[11]	Payroll/ Benefits		3,499,854		35,405,188
[12]	Other Operating Costs		2,473,744		23,719,936
[13]	Capital Spending		26,579		426,844
[14]	Debt serv payments (Hosp onlyw/ LOC interest)		56,055		586,924
[15]	Other (increase) in AP /other bal sheet		(733,371)		(5,912,092)
[16]	**TOTAL DISBURSEMENTS**		**5,322,861**		**54,226,801**
[17]	**TOTAL CHANGE in CASH**		**692,166**		**(696,256)**
	ENDING CASH BALANCES				
[18]	Ending Balances- HOSPITAL	3/31	$408,689	3/31	$408,689
[19]	Ending Balances- DISTRICT	3/31	2,340,154	3/31	2,340,154
[20]	Ending Balances- TOTALS	3/31	$2,748,844	3/31	$2,748,844
ADDITIONAL INFO					
[21]	LOC CURRENT BALANCES		12,000,000		12,000,000
[22]	LOC Interest Expense Incurred		56,055		275,527

SUPPLEMENTAL CASH FLOW SUMMARY (By Program)		Current Month 03/31/2020	Current Year-To-Date 03/31/2020
	IGT/SUPPLEMENTAL CASH INFLOWS		
[24]	HQAF Managed Care Funds	346,199	159,875
[25]	Prime IGT	0	525,000
[26]	Rate Range Managed Care IGTs	(1,284,336)	(1,284,336)
[27]	AB 113	581,741	581,741
[28]	HQAF FFS Direct Grants	0	503,027
[29]	IEHP MCE Bed Funds	0	82,414
[30]	MediCal Outpatient SRH Program	25,000	75,977
[31]	Foundation Contributions	0	163,112
[32]	AB 915 newly Eligible	0	0
[33]	Cost Report Settlements	130,135	35,514
[34]	Medi-CAL DSH	0	(95,789)
[35]	**TOTALS (see line 8 above)**	**(201,261)**	**746,536**

Patient Statistics

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
NINE MONTHs ENDING MAR 31, 2020

Line Ref	Actual 03/31/20	Budget 03/31/20	Prior Year 03/31/19		STATISTICS	Year-To-Date Actual 03/31/20	Budget 03/31/20	Prior Year 03/31/19	YTD % VAR Vs Bud	YTD % VAR Vs Prior Yr
					Discharges					
[1]	201	286	289		Acute	2,065	2,303	2,158	-10.33%	-4.31%
[2]	3.30	2.70	2.88		O/P Adjustment Factor	3.34	3.19	3.23	4.54%	3.48%
[3]	664	771	832		Adjusted Acute Discharges	6,892	7,353	6,961	-6.26%	-0.98%
[4]	14	30	19		Newborn	195	210	211	-7.14%	-7.58%
[5]	215	316	308		Total Discharges	2,260	2,513	2,369	-10.07%	-4.60%
					Patient Days:					
[6]	616	1,118	1,052	-44.9%	Acute	6,819	7,804	7,347	-12.62%	-7.19%
[7]	28	60	0		Newborn	390	420	328	-7.14%	18.90%
[8]	644	1,178	1,052		Total Patient Days	7,209	8,224	7,675	-12.34%	-6.07%
					Average Length of Stay (ALOS)					
[9]	3.06	3.91	3.64		Acute	3.30	3.39	3.40	-2.55%	-3.01%
[10]	2.0	2.0	0.0		Newborn ALOS	2.0	2.0	1.6	0.00%	28.66%
					Average Daily Census (ADC)					
[11]	19.9	36.1	33.9		Acute	24.8	28.4	26.7	-12.62%	-7.19%
[12]	0.9	1.9	0.0		Newborn	1.4	1.5	1.2	-7.14%	18.90%
					Emergency Dept. Statistics					
[13]	177	254	271		ED Visits - Admitted	1,878	2,048	1,907	-8.28%	-1.52%
[14]	1,285	1,525	1,537		ED Visits - Higher Acuity Ops	13,650	14,026	14,115	-2.68%	-3.29%
[15]	1,435	1,827	2,182		ED - Rapid Care Visits Ops	16,778	16,506	16,729	1.65%	0.29%
[16]	**2,897**	**3,606**	**3,990**	-19.7%	**Total ED Visits**	**32,306**	**32,580**	**32,751**	-0.84%	-1.36%
[17]	6.11%	7.05%	6.79%		% of ER Visits Admitted	5.81%	6.28%	5.82%	-7.50%	-0.16%
[18]	88.06%	88.91%	93.77%		ER Admissions as a % of Tot	90.94%	88.91%	88.37%	2.29%	2.91%
					Other Key Statistics:					
[19]	3,405	4,422	4,648		Total Outpatients Visits	37,746	39,484	38,669	-4.40%	-2.39%
[20]	133	229	218		Observation Bed Days	1,376	1,601	1,573	-14.05%	-12.52%
[21]	17.8%	17.0%	17.2%		Obs. Bed Days as a % of Tot	16.8%	17.0%	17.6%	-1.36%	-4.78%
[22]	391	531	546		Behavioral Health Visits	4,037	4,794	4,939	-15.79%	-18.26%
[23]	38	46	47	-17.4%	IP Surgeries	369	321	313	14.95%	17.89%
[24]	22	65	78		OP Surgeries	362	590	608	-38.64%	-40.46%
[25]	139	209	86		Outpatient Scopes	1,543	1,891	766	-18.40%	101.44%
					Productivity Statistics:					
[26]	446.32	455.70	456.21	-2.1%	FTE's - Worked	439.31	455.70	429.63	-3.60%	2.25%
[27]	467.58	489.60	476.23	-4.5%	FTE's - Paid	473.86	489.60	465.48	-3.22%	1.80%
[28]	6.80	4.78	4.67		Worked FTE's per AOB	5.31	4.78	4.99	11.05%	6.47%
[29]	7.12	5.13	4.88		Paid FTE's per AOB	5.73	5.13	5.40	11.61%	6.00%
[30]	1.4780	1.2621	1.2621	17.1%	Case Mix Index -Medicare	1.3147	1.2621	1.2621	4.17%	4.17%
[31]	1.2091	1.0419	1.0419		Case Mix Index - All payers	1.0755	1.0419	1.0419	3.23%	3.23%

AR Report

31-Mar-20

A/R & CASH FLOW TRENDS

	GROSS ACCTS RECEIVABLE BY PAYOR	FY 20	Prior Year	Monthly Trends			
		31-Mar-20	FY 19	FY 20	FY 20	FY 20	FY 20
		ACTUAL	JUNE	DEC	JAN	FEB	MAR
1	Blue Shield	240,810	233,330	260,000	296,045	235,129	240,810
2	Blue Cross	1,492,761	1,946,555	2,042,815	1,929,945	2,160,182	1,492,761
3	MediCal	2,452,564	1,701,380	2,960,419	2,663,483	2,931,618	2,452,564
4	IEHP /Other MediCal HMO	5,553,306	6,301,624	7,816,990	8,381,821	7,168,857	5,553,306
5	Champus /Other Govt	2,653,900	2,835,303	3,446,635	3,475,736	3,255,431	2,653,900
6	HMO/PPO/Commercial	8,078,822	7,323,981	7,351,542	7,778,951	8,546,604	8,078,822
7	Medicare	5,161,203	8,498,471	6,097,723	6,474,602	7,745,560	5,161,203
8	Self Pay/Credit Bals	5,513,117	6,670,232	6,599,688	6,279,471	5,709,143	5,513,117
9	Senior HMO	14,408,154	13,054,309	14,385,596	13,719,027	13,845,577	14,408,154
10	Workers Comp	282,528	645,516	657,837	315,858	235,196	282,528
11	TOT GROSS AR	45,837,165	49,210,701	51,619,247	51,314,939	51,833,299	45,837,165

	PATIENT CASH COLLECTIONS	FY 20	FY 19	FY 20	FY 20	FY 20	FY 20
		Year-To Date	Year-To Date	DEC	JAN	FEB	MAR
12	Blue Shield	341,067	320,943	31,126	35,033	36,966	20,522
13	Blue Cross	1,602,533	1,577,007	235,167	159,365	134,597	176,704
14	Medi-Cal	1,845,911	1,947,861	207,989	249,807	144,273	194,804
15	IEHP /Other MediCal HMO	5,974,280	5,903,225	896,604	695,028	625,514	662,568
16	Champus /Other Govt	860,772	652,797	84,421	84,804	68,860	67,394
17	HMO/PPO/Commercial	6,518,598	6,145,163	694,023	622,792	603,853	759,450
18	Medicare	7,225,521	6,086,503	815,339	707,683	519,453	1,243,832
19	Self Pay/Credit Bals	1,161,797	1,125,768	86,896	154,365	99,816	140,720
20	Senior HMO	10,110,457	9,003,289	1,077,650	1,314,028	1,148,032	1,003,938
21	Workers Comp	137,625	152,824	12,446	16,660	19,205	15,822
22	TOT CASH COLLECTIONS	35,437,493	32,915,380	4,141,663	4,039,564	3,400,568	4,285,756
	Percent Change vs. Prior>						
23	% change vs. Prior yr.>		7.7%	115.7%	115.4%	115.6%	115.5%

	GROSS DAYS IN AR BY PAYOR	FY 20	FY 19	TARGET	FY 20	FY 20	FY 20	FY 20
		Year-To Date	06/30/2019	10/31/2016	DEC	JAN	FEB	MAR
24	Blue Shield	40.6	30.7	60.4	39.8	43.3	32.4	40.6
25	Blue Cross	49.2	55.6	44.6	55.6	58.4	64.4	49.2
26	MediCal	72.0	57.0	66.3	94.5	76.1	79.3	72.0
27	IEHP /Other MediCal HMO	27.9	27.3	27.5	33.7	36.6	33.1	27.9
28	Champus /Other Govt	107.1	147.6	132.2	159.7	173.6	142.0	107.1
29	HMO/PPO/Commercial	99.1	96.0	86.4	88.1	93.2	98.4	99.1
30	Medicare	47.3	58.0	36.3	51.8	54.7	63.9	47.3
31	Self Pay/Credit Bals	105.3	82.5	80.5	113.9	105.9	96.7	105.3
32	Senior HMO	73.1	64.5	59.5	69.8	66.0	67.8	73.1
33	Workers Comp	85.8	111.6	136.2	82.7	42.5	41.5	85.8
34	TOT GROSS DAYS IN AR	62.14	59.00	53.9	64.44	64.10	65.25	62.14

TAB L

SAN GORGONIO MEMORIAL HOSPITAL
Medical Staff Services Department

M E M O R A N D U M

DATE: April 15, 2020

TO: Susan DiBiasi, Chair
Governing Board

FROM: Steven Hildebrand, M.D., Chairman
Medical Executive Committee

SUBJECT: MEDICAL EXECUTIVE COMMITTEE REPORT

At the Medical Executive Committee held this date, the following items were recommended for approval by the Governing Board:

Approval Item(s):
COVID-19 ICU and Non-ICU Order Set
This initial COVID-19 ICU and Non-ICU order set was recommended for approval, subject to change when necessary (See attached).

A taskforce was formulated under the direction of Dr. Karan Singh, who is working with the hospitalists, to review and make changes to the order set when needed.

Implementing a Closed-Staff System for the SGMH Anesthesiology Service
The following are revisions made to the November 20, 2019, Medical Executive Committee minutes on the aforementioned topic:

In order to attract a good quality Anesthesia medical group to service our hospital including taking call 24/7 and providing care without regard to insurance or financial or social status, the hospital needs to guarantee the group exclusive access to all of the patients. Allowing another group or individual anesthesiologist to "cherry pick" more profitable or desirable patients would make contracting with a group impossible.

The medical staff did send out a letter asking for input into making this decision. We only received two replies. Both were from other hospital based physicians who asked if we could close their departments as well. There were no comments made in opposition.

The MEC is aware that the hospital is negotiating a contract with the Beaver Medical Group to cover anesthesia. From the perspective of quality and service, there was no opposition expressed to contracting with the Beaver Medical Group to provide this service.

2020 Medical Staff Bylaws

The MEC recommends approval of the Medical Staff Bylaws for the year 2019/2020. There were no revisions made to the bylaws.

COVID 19 ICU AND NON ICU ORDER SET

- [x] ICU
  - [x] MEDICATIONS:
    - [x] hydroxyCHLOROQUINE 400MG ORAL Q12H X2 DOSES
      (WITH MEALS HOLD FOR QTc GREATER THAN 520 mS AND NOTIFY PHYSICIAN)
    - [x] hydroxyCHLOROQUINE 200MG ORAL Q12H X4 DAYS
      (WITH MEALS HOLD FOR QTc GREATER THAN 520 mS AND NOTIFY PHYSICIAN)
    - [x] ACETAMINOPHEN 650MG ORAL Q4H PRN
      (AS NEEDED FOR TEMPERATURE OVER 103.1F)
    - [ ] ZINC SULFate 220MG ORAL DAILY X5 DAYS
    - [ ] ASCORBIC ACID 12GM IV Q12H X7 DAYS
      (****CENTRAL LINE ONLY***** PROTECT FROM LIGHT INFUSE OVER 5 HOURS)
    - [ ] THIAMINE 100MG ORAL DAILY X5 DAYS
    - [ ] THIAMINE 200MG IV Q12H X5 DAYS
      (INFUSE OVER 30 MINUTES)
    - [ ] LOSartan 25MG ORAL DAILY
      (Check BP BEFORE giving BP meds; enter BP in MAR)
    - [ ] LOSartan 50MG ORAL DAILY
      (Check BP BEFORE giving BP meds; enter BP in MAR)
    - [ ] ATORVAstatin 40MG ORAL BEDTIME
      (DO NOT ADMINISTER WITH GRAPEFRUIT JUICE)
  - [x] LABS / EKG :
    - [x] DAILY:
      - [x] CPK (Creatine Kinase)
      - [x] BNP
      - [x] LDH
      - [x] Troponin - I Level
      - [x] EKG
    - [x] STAT x 1:
      - [x] Procalcitonin
      - [x] Immunoglobulin, IgG S/O
      - [x] Ferritin
      - [x] BioFire Respiratory Panel
      - [ ] HIV 1/2 Screen, rapid
      - [ ] Legionella Antigen, Urine S/O
      - [ ] Aldosterone, LC/MS/MS, serum S/O
      - [ ] Renin
      - [ ] Angiotensin-1-Converting Enzyme S/O
      - [ ] Fungitell, (1-3)-B-D-Glucan Assay

COVID 19 ICU AND NON ICU ORDER SET

- [x] NON ICU
  - [x] MEDICATIONS:
    - [x] hydroxyCHLOROQUINE 400MG ORAL Q12H X 2 DOSES
      (WITH MEALS HOLD FOR QTc GREATER THAN 520 mS AND NOTIFY PHYSICIAN)
    - [x] hydroxyCHLOROQUINE 200MG Q12H X4 DAYS
      (WITH MEALS HOLD FOR QTc GREATER THAN 520 mS AND NOTIFY PHYSICIAN)
    - [x] ACETAMINOPHEN 650MG ORAL Q4H PRN
      (AS NEEDED FOR TEMPERATURE OVER 103.1F)
    - [x] ASCORBIC ACID 1GM ORAL Q6H X7 DAYS
    - [x] ZINC SULFate 220MG ORAL DAILY X5 DAYS
    - [x] THIAMINE HCL 100MG ORAL DAILY X5 DAYS
    - [ ] THIAMINE HCL 200MG IV Q12 X5 DAYS
      (INFUSE OVER 30 MINUTES)
    - [ ] LOSartan 25MG ORAL DAILY
      (Check BP BEFORE giving BP meds; enter BP in MAR)
    - [ ] LOSartan 50MG ORAL DAILY
      (Check BP BEFORE giving BP meds; enter BP in MAR)
    - [ ] ATORVAstatin 40MG ORAL AT BEDTIME
      (DO NOT ADMINISTER WITH GRAPEFRUIT JUICE)
  - [x] LABS / EKG :
    - [x] DAILY
      - [x] Complete Blood Count
      - [x] CMP (includes LFT, but not DBIL)
      - [x] Magnesium
      - [x] Phosphorus
      - [x] CPK
      - [x] BNP
      - [x] LDH
      - [x] Troponin - I Level
      - [x] EKG
    - [x] STAT x 1 on ADMISSION:
      - [x] CMP (includes LFT, but not DBIL)
      - [x] D - Dimer Quant
      - [x] Cortisol, Total
      - [x] Urinalysis,w/ CULTURE, if indicated.
      - [x] Culture, Blood 1 of 2
      - [x] Culture, Blood 2 of 2
      - [x] Procalcitonin
      - [x] Immunoglobulin, IgG S/O
      - [x] Ferritin
      - [x] BioFire Respiratory Panel
      - [ ] HIV 1/2 Screen, rapid
      - [ ] Legionalla Pneumonphila Antigen, DFA
      - [ ] Aldosterone, LC/MS/MS, serum S/O
      - [ ] Renin
      - [ ] Angiotensin-1-Converting Enzyme S/O
      - [ ] Fungitell, (1-3)-B-D-Glucan Assay

MEDICAL STAFF BYLAWS

2020

TABLE OF CONTENTS

ARTICLE I. NAME……………………………………………………………………………….. 3
ARTICLE II. PURPOSES…………………………………………………………………………… 3
SECTION 2.1 PURPOSES OF ORGANIZATION………………..………….……..……..... 3

ARTICLE III. MEMBERSHIP…………………….……………………………………………… 4
SECTION 3.1 NATURE OF MEMBERSHIP……………………………………….…………… 4

SECTION 3.2 QUALIFICATIONS FOR MEMBERSHIP………………………………….…… 4
SECTION 3.2.1 GENERAL QUALIFICATIONS………………………..………….………….. 4
SECTION 3.2.2 PARTICULAR QUALIFICATIONS……………………..…….….………… 5

SECTION 3.3 EFFECT OF OTHER AFFILIATIONS.……..………………………………… 5
SECTION 3.4 NONDISCRIMINATION.……..……………………………………………………. 5
SECTION 3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP……… 6
SECTION 3.6 STANDARD OF CONDUCT……………………………………………….. 7
SECTION 3.7 HARASSMENT PROHIBITED……………………………………………… . 8
SECTION 3.8 EXCLUSIVE CONTRACTS/INDEPENDENT CONTRACTORS..……..… 9

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF…………………………..…………….. 10
SECTION 4.1 CATEGORIES…………………………………………………..…….……10

SECTION 4.2 RESPONSIBILITIES AND PREROGATIVES…………………….………….. 10

SECTION 4.3 ACTIVE STAFF ……………………..…….…………………………………….. 11
SECTION 4.3.1 QUALIFICATIONS……………………………………………………….. 11
SECTION 4.3.2 PREROGATIVES/RESPONSIBILITIES………………………….. 12
SECTION 4.3.3 TRANSFER OF ACTIVE STAFF MEMBER……………………… 12

SECTION 4.4 COURTESY MEDICAL STAFF……………………………..……..…… 12
SECTION 4.4.1 QUALIFICATIONS……………………………………………….. 12
SECTION 4.4.2 PREROGATIVES/RESPONSIBILITIES………………………….. 13

SECTION 4.5 CONSULTING MEDICAL STAFF…………………………………………… 13
SECTION 4.5.1 QUALIFICATIONS………………………………………………….. 13
SECTION 4.5.2 PREROGATIVES/RESPONSIBILITIES………………………….. 14

SECTION 4.6 ASSOCIATE MEDICAL STAFF…………………………………………… 14
SECTION 4.6.1 QUALIFICATIONS………………………………………………… 14
SECTION 4.6.2 PREROGATIVES…………………………………………………. 15

SECTION 4.7 HONORARY AND RETIRED STAFF…..………………………………… 15
SECTION 4.7.1 QUALIFICATIONS………………………………………………… 15
SECTION 4.7.2 PREROGATIVES/RESPONSIBILITIES…...…………………… 15

SECTION 4.8 TELEMEDICINE AFFILIATE STAFF…..………………………………… 15
SECTION 4.8.1 EXPLANATION………………………………………………… 15
SECTION 4.8.2 DEFINITIONS…..……………………………………………… 16
SECTION 4.8.3 PREROGATIVES AND LIMITATIONS…………………….……… 16

SECTION 4.9 PROVISIONAL STATUS………………..……………………………… 17
SECTION 4.9.1 DEFINITIONS………………………………………………… 17
SECTION 4.10 CHANGE IN STAFF CATEGORY………..…………………………… 18

SECTION 4.11 LIMITATION OF PREROGATIVES……………………..………….……..……... 18
SECTION 4.12 EMERGENCY ON-CALL PANEL………………….……….……..……...... 18

ARTICLE V. ALLIED HEALTH PROFESSIONALS…………………………………………….. 19
SECTION 5.1 DEFINITIONS………………………………………………….…………… 19
SECTION 5.2 QUALIFICATIONS…………………………….……………………………. 19
SECTION 5.3 PROCEDURE FOR APPOINTMENT AND DELINEATION OF PRACTICE PRIVILEGES……………………………………………….. 20
SECTION 5.4 PREROGATIVES…………………………….…………………………….. 20
SECTION 5.5 RESPONSIBILITIES…………………………..…………………………… 21
SECTION 5.6 AUTOMATIC TERMINATION…………………..…………………………… 22

ARTICLE VI. PROCEDURES FOR REVIEW, APPOINTMENT AND REAPPOINTMENT (Including Telemedicine Services)…………………………. 22
SECTION 6.1 GENERAL………………………………………….……………………… 22
SECTION 6.2 BURDEN OF PRODUCING INFORMATION.……………………………… 23
SECTION 6.3 APPOINTMENT AUTHORITY…………………………………………….. 23
SECTION 6.4 DURATION OF APPOINTMENT AND REAPPOINTMENT…………….… 23

SECTION 6.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT……………..…………………………………………….. 23
SECTION 6.5.1 APPLICATION FORM……………………….…….………………… 23
SECTION 6.5.2 EFFECT OF APPLICATION……..…………………….…….……… 25
SECTION 6.5.3 VERIFICATION OF INFORMATION…….…………….……………… 26
SECTION 6.5.4 SERVICE ACTION……………….……………………….…….…… 27
SECTION 6.5.5 CREDENTIALS COMMITTEE ACTION.…………………………….. 27
SECTION 6.5.6 MEDICAL EXECUTIVE COMMITTEE ACTION.…….…….………… 28
SECTION 6.5.7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION…… 28
SECTION 6.5.8 ACTION ON THE APPLICATION..…………………….…….……… 28
SECTION 6.5.9 NOTICE OF FINAL DECISION..……………….…………….……… 30
SECTION 6.5.10 REAPPLICATION AFTER ADVERSE DECISION……….………… 30
SECTION 6.5.11 TIMELY PROCESSING OF APPLICATIONS…………….…………. 31
SECTION 6.5.12 EXPEDITED CREDENTIALING APPROVAL PROCESS……… 32

SECTION 6.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STATUS OR PRIVILEGES…………………………………………………. 33
SECTION 6.6.1 APPLICATION FOR REAPPOINTMENT.………..………………… 33
SECTION 6.6.2 EFFECT OF APPLICATION……………..…………………………… 34
SECTION 6.6.3 STANDARDS AND PROCEDURE FOR REVIEW..……………… 35
SECTION 6.6.4 EXTENSION OF APPOINTMENT……...…………………………… 35
SECTION 6.6.5 FAILURE TO FILE REAPPOINTMENT APPLICATION………… 35
SECTION 6.6.6 NO VOLUME PHYSICIANS…………………………………….. 35

SECTION 6.7 LEAVE OF ABSENCE……………………………………………………. 35
SECTION 6.7.1 LEAVE STATUS………………………..……………………………… 35
SECTION 6.7.2 TERMINATION OF LEAVE……………...…………………………… 36
SECTION 6.7.3 FAILURE TO REQUEST REINSTATEMENT..…………………… 36
SECTION 6.7.4 MEDICAL LEAVE OF ABSENCE……...…………………………….. 36
SECTION 6.7.5 MILITARY LEAVE OF ABSENCE…………………………………… 37
SECTION 6.7.6 VOLUNTARY TERMINATION OF MEMBERSHIP AND PRIVILEGES……………………………………………………….. 37
SECTION 6.7.7 REINSTATEMENT TO MEDICAL STAFF……….………………… 37

ARTICLE VII. CLINICAL PRIVILEGES………………………..…………………………….. 38
SECTION 7.1 EXERCISE OF PRIVILEGES……………………………………………… 38

SECTION 7.2 DELINEATION OF PRIVILEGES IN GENERAL …………………….…… 38
SECTION 7.2.1 REQUESTS………………………………………………………… 38
SECTION 7.2.2 BASIS FOR PRIVILEGES DETERMINATION…………………… 38
SECTION 7.3 PROCTORING………………………………. ………………………… 39
SECTION 7.3.1 OBSERVATION OF MEDICAL STAFF MEMBERS……………… 39
SECTION 7.3.2 FAILURE TO OBTAIN CERTIFICATION……………………….. 40
SECTION 7.3.3 MEDICAL STAFF ADVANCEMENT……………..………………… 41
SECTION 7.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS……………………..…… ………………………… 41
SECTION 7.4.1 ADMISSIONS……………………………………………………… 41
SECTION 7.4.2 SURGERY……………………………………………………….. 41
SECTION 7.4.3 MEDICAL APPRAISAL……………..………..…………………… 42
SECTION 7.5 TEMPORARY CLINICAL PRIVILEGES……….……………………… 42
SECTION 7.5.1 CIRCUMSTANCES…………………………….………………… 42
SECTION 7.5.2 APPLICATION AND REVIEW…………………………………… 43
SECTION 7.5.3 GENERAL CONDITIONS………………..…………………… 43
SECTION 7.5.4 TERMINATION……………………………………………………… 44
SECTION 7.5.5 RIGHTS OF THE PRACTITIONER………..…………………… 44

SECTION 7.6 EMERGENCY PRIVILEGES…………………. ………………………… 44
SECTION 7.7 MODIFICATION OF CLINICAL PRIVILEGES OR SERVICE ASSIGNMENT………………………………. …………………………… 46
SECTION 7.8 LAPSE OF APPLICATION…………………. …………………………… 46

ARTICLE VIII. CORRECTIVE ACTION……………………………………………………….. 46
SECTION 8.1 OVERVIEW…………………..………………. ……………………………. 46
SECTION 8.1.1 GOALS……………………………………………..……………… 46
SECTION 8.1.2 PARTICIPATION AND PEER REVIEW…………………………… 47

SECTION 8.2 CORRECTIVE ACTION……..………………. ………………………….. 47
SECTION 8.2.1 CRITERIA AND INITIATION…………………….……………… 47
SECTION 8.2.2 INITIATION…………………………..………………………… 48
SECTION 8.2.3 INVESTIGATION……………………..………………………… 48
SECTION 8.2.4 MEDICAL EXECUTIVE COMMITTEE ACTION….……………… 49
SECTION 8.2.5 SUBSEQUENT ACTION………………..………………………… 50
SECTION 8.2.6 FAILURE TO INVESTIGATE OR TAKE DISCIPLINARY ACTION 50
SECTION 8.3 SUMMARY RESTRICTION OR SUSPENSION………………………… 50
SECTION 8.3.1 CRITERIA FOR INITIATION……………………………………… 50
SECTION 8.3.2 MEDICAL EXECUTIVE COMMITTEE ACTION…………………… 51
SECTION 8.3.3 PROCEDURAL RIGHTS………………..………………………… 51
SECTION 8.3.4 INITIATION BY THE GOVERNING BODY……………………… 52
SECTION 8.4 AUTOMATIC SUSPENSION OR LIMITATION……………….……… 52
SECTION 8.4.1 LICENSURE……………….………………………..…………… 52
SECTION 8.4.2 CONTROLLED SUBSTANCES…………………………………… 53
SECTION 8.4.3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENTS.…………………………………………………… 53
SECTION 8.4.4 MEDICAL RECORDS……………………………………………… 53
SECTION 8.4.5 FAILURE TO PAY DUES/ASSESSMENTS……………………… 54
SECTION 8.4.6 PROFESSIONAL LIABILITY INSURANCE.……………………… 54

ARTICLE IX. HEARINGS AND APPELLATE REVIEWS……………………………….….. 54
SECTION 9.1 GENERAL PROVISIONS……………..…………….…….…………… 54
SECTION 9.1.1 INTRA-ORGANIZATIONAL REMEDIES…………..……………… 54
SECTION 9.1.2 EXHAUSTION OF REMEDIES…………………………………….. 55

SECTION 9.1.3 APPLICATION OF ARTICLE…………………………………………… 55
SECTION 9.1.4 TIMELY COMPLETION OF PROCESS…………………………… 55
SECTION 9.1.5 FINAL ACTION…………………………………………………… 55
SECTION 9.2 GROUNDS FOR HEARING……………………………………………… 55
SECTION 9.3 REQUESTS FOR HEARING…………………………………………… 56
SECTION 9.3.1 NOTICE OF ACTION OR PROPOSED ACTION………………… 56
SECTION 9.3.2 REQUEST FOR HEARING………………………………………. 56
SECTION 9.3.3 TIME AND PLACE FOR HEARING…………………………… 57
SECTION 9.3.4 NOTICE OF CHARGES…………………………………………… 57
SECTION 9.3.5 JUDICAL REVIEW COMMITTEE………………………………… 57
SECTION 9.3.6 FAILURE TO APPEAR OR PROCEED…………………………… 58
SECTION 9.3.7 CONTINUANCES…………………………………………………… 58
SECTION 9.4 HEARING PROCEDURE………………………………………………… 58
SECTION 9.4.1 PREHEARING PROCEDURE………………………………………… 58
SECTION 9.4.2 REPRESENTATION…………………………………………………… 59
SECTION 9.4.3 THE HEARING OFFICER……………………………………………. 60
SECTION 9.4.4 RECORD OF THE HEARING………………………………………… 60
SECTION 9.4.5 RIGHTS OF THE PARTIES…………………………………………. 60
SECTION 9.4.6 MISCELLANEOUS RULES…………………………………………… 61
SECTION 9.4.7 BURDENS OF PRESENTING EVIDENCE AND PROOF……….. 61
SECTION 9.4.8 ADJOURNMENT AND CONCLUSION……………………………. 61
SECTION 9.4.9 BASIS FOR DECISION…………………………………………….. 62
SECTION 9.4.10 DECISION OF THE JUDICIAL REVIEW COMMITTEE………… 62
SECTION 9.5 APPEAL……………………………………………………………………. 62
SECTION 9.5.1 TIME FOR APPEAL……………………………………………….. 62
SECTION 9.5.2 GROUNDS FOR APPEAL………………………………………… 63
SECTION 9.5.3 TIME, PLACE AND NOTICE……………………………………. 63
SECTION 9.5.4 APPEAL BOARD…………………………………………………….. 63
SECTION 9.5.5 APPEAL PROCEDURE……………………………………………… 64
SECTION 9.5.6 DECISION…………………………………………………………… 64
SECTION 9.5.7 RIGHT TO ONE HEARING……………………………………….. 65
SECTION 9.6 EXCEPTIONS TO HEARING RIGHTS……………………………… 65
SECTION 9.6.1 MEDICAL ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS……………………………………………………… 65
SECTION 9.6.2 AUTOMATIC SUSPENSION OR LIMITATION OF CLNIICAL PRIVILEGES…………………………………………………… 65
SECTION 9.6.3 ALLIED HEALTH PROFESSIONALS……………………………. 66
SECTION 9.6.4 NATIONAL PRACTITIONER DATA BANK REPORTING……… 66
SECTION 9.6.5 DISPUTING REPORT LANGUAGE……………………………… 66
SECTION 9.6.6 EXCEPTIONS TO HEARING RIGHTS…………………………… 67

ARTICLE X. OFFICERS………………………………………………………………….. 68
SECTION 10.1 OFFICERS OF THE MEDICAL STAFF………………………………. 68
SECTION 10.1.1 IDENTIFICATION OF ELECTED OFFICERS……………………. 68
SECTION 10.1.2 QUALIFICATIONS OF ELECTED OFFICERS…………………… 68
SECTION 10.1.3 NOMINATIONS AND ELECTIONS………………………………… 68
SECTION 10.1.4 TERM OF ELECTED OFFICERS…………………………………. 69
SECTION 10.1.5 RECALL OF ELECTED OFFICERS………………………………… 69
SECTION 10.1.6 VACANCIES IN ELECTED OFFICE…………………………… 69
SECTION 10.2 DUTIES OF OFFICERS…………………………………………………… 69
SECTION 10.2.1 CHIEF OF STAFF……………………………………………………….. 69
SECTION 10.2.2 CHIEF OF STAFF-ELECT……………………………………………… 71
SECTION 10.2.3 IMMEDIATE PAST CHIEF OF STAFF……………………………… 71
SECTION 10.2.4 TREASURER………………………………………………………… 71

ARTICLE XI. SERVICES AND SUBSECTIONS………………………………………………….. 72
SECTION 11.1 ORGANIZATION OF SERVICES……………….. …………………………… 72
SECTION 11.2 CURRENT SERVICES AND SUBSECTION……………………………… 72
SECTION 11.3 ASSIGNMENT TO SERVICES………..…… ……………………………. 73
SECTION 11.4 FUNCTIONS OF SERVICES…………… ………………………………….. 73
SECTION 11.5 FUNCTIONS OF SUBSECTIONS……………. …………………………… 75
SECTION 11.6 SERVICE CHIEFS, VICE CHIEFS AND MEDICAL COMMITTEE……… 75
SECTION 11.6.1 QUALIFICATIONS………………………………………………… 75
SECTION 11.6.2 SELECTION OF SERVICE CHIEFS, VICE CHIEFS, MEDICAL STAFF COMMITTEE MEMBERS..………………………………… 75
SECTION 11.6.3 TERM OF OFFICE………………………………………………… 75
SECTION 11.6.4 REMOVAL OF SERVICE CHIEFS AND VICE CHIEFS………… 75
SECTION 11.6.5 DUTIES OF SERVICE CHIEFS…………………………………… 76
SECTION 11.6.6 DUTIES OF SERVICE CHIEFS AND COMMITTEE CHAIRS…… 77

ARTICLE XII. COMMITTEES………………………………………………………………….. 79
SECTION 12.1 DESIGNATION…………………………… …………………………… 79
SECTION 12.2 COMMITTEES MEMBERS, TERMS, REMOVAL, AND VACANCIES…. 80
SECTION 12.3 MEDICAL EXECUTIVE COMMITTEE………………………………….…80
SECTION 12.3.1 COMPOSITION……………………………………………………… 80
SECTION 12.3.2 DUTIES………………………………………………………………….. 81
SECTION 12.3.3 MEETINGS…………………………………………………………… 83

SECTION 12.4 BYLAWS COMMITTEE…………………………………………………….. 83
SECTION 12.4.1 COMPOSITION……………………………………………………… 83
SECTION 12.4.2 DUTIES………………………………………………………………… 83
SECTION 12.4.3 MEETINGS…………………………………………………………… 84

SECTION 12.5 CREDENTIALS COMMITTEE……………………………………………... 84
SECTION 12.5.1 COMPOSITION……………………………………………………… 84
SECTION 12.5.2 DUTIES………………………………………………………………… 84
SECTION 12.5.3 MEETINGS…………………………………………………………… 84

SECTION 12.6 MEDICAL ETHICS COMMITTEE…………………………………………….. 84
SECTION 12.6.1 COMPOSITION……………………………………………………… 84
SECTION 12.6.2 DUTIES………………………………………………………………… 85
SECTION 12.6.3 MEETINGS…………………………………………………………… 86

SECTION 12.7 INFECTION CONTROL/PHARMACY & THERAPEUTICS COMMITTEE. 86
SECTION 12.7.1 COMPOSITION……………………………………………………… 86
SECTION 12.7.2 DUTIES………………………………………………………………… 86
SECTION 12.7.3 MEETINGS…………………………………………………………… 87
SECTION 12.8 PHYSICIAN WELL BEING COMMITTEE………………………………… 87
SECTION 12.8.1 COMPOSITION……………………………………………………… 88
SECTION 12.8.2 DUTIES………………………………………………………………… 88
SECTION 12.8.3 MEETINGS…………………………………………………………… 88
SECTION 12.9 INTERDISCIPLINARY PRACTICE COMMITTEE………………………… 89
SECTION 12.9.1 COMPOSITION/ORGANIZATION…………………………………. 89
SECTION 12.9.2 DUTIES………………………………………………………………… 89
SECTION 12.9.3 MEETINGS…………………………………………………………… 90

SECTION 12.10 MEDICAL STAFF QUALITY COUNCIL COMMITTEE……………………………90
SECTION 12.10.1 COMPOSITION……………………………………………………… 90
SECTION 12.10.2 CHAIRMAN………………………………………………………… 91
SECTION 12.10.3 DUTIES……………………………………………………………… 91
SECTION 12.10.4 MEETINGS………………………………………………………… 92

SECTION 12.11 UTILIZATION MANAGEMENT COMMITTEE…………………………….. 92
SECTION 12.11.1 COMPOSITION……………………………………………………… 92
SECTION 12.11.2 DUTIES……………………………………………………………… 92
SECTION 12.11.3 MEETINGS………………………………………………………… 93

SECTION 12.12 EDUCATION COMMITTEE……………………………………………….. 93
SECTION 12.12.1 COMPOSITION……………………………………………………… 93
SECTION 12.12.2 PURPOSE…………………………………………………………… 93
SECTION 12.12.3 OTHER……………………………………………………………… 93
SECTION 12.12.4 MEETINGS………………………………………………………… 93

SECTION 12.13 JOINT CONFERENCE COMMITTEE…………………………………….. 94
SECTION 12.13.1 COMPOSITION……………………………………………………… 94
SECTION 12.13.2 DUTIES……………………………………………………………… 94
SECTION 12.13.3 MEETINGS………………………………………………………… 94

SECTION 12.14 PEER REVIEW COMMITTEE (PRC)……………………………………. 94
SECTION 12.14.1 COMPOSITION……………………………………………………… 94
SECTION 12.14.2 DUTIES……………………………………………………………… 95
SECTION 12.14.3 MEETINGS………………………………………………………… 96

SECTION 12.15 SPECIAL COMMITTEES……………………………………………………. 96
ARTICLE XIII. MEDICAL STAFF MEETINGS……………………………………………….. 96
SECTION 13.1 GENERAL STAFF MEETINGS…………………………………………… 96
SECTION 13.2 SPECIAL MEETING……………………………………………………… 96
SECTION 13.2.1 REQUEST…………………………………………………………… 96
SECTION 13.2.2 NOTICE……………………………………………………………… 97
SECTION 13.2.3 QUORUM…………………………………………………………….. 97

SECTION 13.3 AGENDA………………………………………………………………… 97
SECTION 13.3.1 GENERAL MEETING…………………………………………………. 97
SECTION 13.3.2 SPECIAL MEETING………………………………………………….. 98

SECTION 13.4 EXECUTIVE SESSION……………………………………………………. 98
SECTION 13.5 COMMITTEE AND SERVICE MEETINGS………………………………… 98
SECTION 13.5.1 REGULAR MEETINGS………………………………………………… 98
SECTION 13.5.2 SPECIAL MEETINGS…………………………………………………. 98
SECTION 13.5.3 NOTICE OF MEETINGS………………………………………………. 98
SECTION 13.5.4 QUORUM……………………………………………………………… 99
SECTION 13.5.5 MANNER OF ACTION…………………………………………………. 99
SECTION 13.5.6 RIGHTS OF EX OFFICIO MEMBERS………………………………….. 99
SECTION 13.5.7 MINUTES……………………………………………………………… 99
SECTION 13.5.8 SPECIAL ATTENDANCE REQUIREMENTS……………………………. 99
SECTION 13.6 VOTING…………………………………………………………………….. 100

ARTICLE XIV. CONFIDENTIALITY, IMMUNITY AND RELEASES………………………….. 100
SECTION 14.1 AUTHORIZATION AND CONDITIONS……………………………………….. 100
SECTION 14.2 CONFIDENTIALITY OF INFORMATION………………………………….. 100

SECTION 14.2.1 GENERAL……………………..………………………..……………… 100
SECTION 14.2.2 BREACH OF CONFIDENTIALITY…………………………………… 101

SECTION 14.3 IMMUNITY FROM LIABILITY……………………………………………….. 101
SECTION 14.3.1 FOR ACTION TAKEN…………………………………………………. 101
SECTION 14.3.2 FOR PROVIDING INFORMATION……………………………………101

SECTION 14.4 ACTIVITIES AND INFORMATION COVERED………………………………. 101

SECTION 14.5 RELEASES………………………………………………………………………. 102

ARTICLE XV. GENERAL PROVISIONS…………………………………..……………………….. 102

SECTION 15.1 RULES AND REGULATIONS……………………..………………………. 102
SECTION 15.2 CONSTRUCTION OF TERMS AND HEADINGS…..………………………. 103
SECTION 15.3 AUTHORITY TO ACT…………….…………………………………….. ……….. 103
SECTION 15.4 DIVISION OF FEES………..……………………...…………….. ……….. 103
SECTION 15.5 NOTICES………………………..………………………………………………. 103
SECTION 15.6 DISCLOSURE OF INTERESTS…………………..…………………………103
SECTION 15.7 NOMINATION OF MEDICAL STAFF REPRESENATIVES………………... 104

ARTICLE XVI. ADOPTION AND AMENDMENT OF BYLAWS………..……………………….. 104

SECTION 16.1 PROCEDURE………………………………………………………………. 104

SECTION 16.2 ACTION ON BYLAW CHANGE………………………………………………. 104
SECTION 16.2.1 EMERGENCY AMENDMENTS TO THE BYLAWS……………… 104

SECTION 16.3 APPROVAL………………………………………………………………… 104
SECTION 16.4 EXCLUSIVITY………………………………………………………………. 105
SECTION 16.5 FREQUENCY OF REVIEW…………………………………………………. 105
SECTION 16.6 EFFECT OF THE BYLAWS…………………………………………………. 105

TAB 1 GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF

TAB 2 RULES AND REGULATIONS OF THE MEDICAL SERVICE

TAB 3 RULES AND REGULATIONS OF THE SURGICAL SERVICE

TAB 4 RULES AND REGULATIONS OF THE EMERGENCY SERVICE

PURPOSE

These Bylaws are adopted in recognition of the mutual accountability, interdependence (HOSPITAL), and responsibility of the Medical Staff of San Gorgonio Memorial Hospital and the Governing Body of the Hospital in protecting the quality of medical care provided in the Hospital and assuring the competency of the Hospital's Medical Staff. These Bylaws provide a framework for self-governance, assuring an organized Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, including but not limited to structuring itself to provide a uniform standard of quality patient care, treatment and services; to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes; and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff.

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

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith. In approving these Bylaws, the Governing Body commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Governing Body will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in any matter pertaining to the quality of patient care.

DEFINITIONS

1. HOSPITAL means San Gorgonio Memorial Hospital.

2. GOVERNING BODY means the Hospital Corporate Board of Directors which is the governing entity of San Gorgonio Memorial Hospital.

3. CHIEF EXECUTIVE OFFICER means the person appointed by the Governing Body to serve in an administrative capacity.

4. MEDICAL STAFF or STAFF means those Physicians, Dentists, Podiatrists, and Clinical Psychologists (see for examples 3.1 and 3.2) who have been granted

recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

5. MEDICAL EXECUTIVE COMMITTEE means the Medical Executive Committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws.

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

7. MEMBER means, unless otherwise expressly limited, any Physician, Dentist, or Podiatrist holding a current license to practice within the scope of one's license as a member of the Medical Staff.

8. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Medical Staff member or other practitioner to provide specific categories or types of patient care and includes unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

9. MEDICAL STAFF FISCAL YEAR means the period from July 1 to June 30.

10. CHIEF OF STAFF means the Chief Officer of the Medical Staff elected by members of the Medical Staff.

11. COMPLETED APPLICATION means an application filed for membership (either new or renewal) in the Medical Staff that is in compliance with all of the requirements in these Bylaws, Rules and Regulations, and with the appropriate Service Rules and Regulations; with respect to which all requested current letters of reference, documents, and any other requested information have been provided, and with respect to which all information documented in the application has been verified.

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

13. INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff, and does not include activity of the Physician Well Being Committee.

14. CHIEF OF MEDICAL OFFICER (CMO) means a California State licensed M.D. or D.O. with recognized clinical expertise that is appointed by the Hospital and approved by the Governing Body to perform certain tasks deemed by the administration to be necessary for the proper operation of the Hospital. He/she

may not be a Member of the Medical Staff and thus not eligible to practice medicine at San Gorgonio Memorial Hospital.

15. Working days are days that are non federal.

ARTICLE I
NAME

1. The name of this organization is the Medical Staff of San Gorgonio Memorial Hospital.

ARTICLE II
PURPOSES

2.1 PURPOSE OF ORGANIZATION

2.1.1 To provide quality medical care to patients admitted to or treated in any of the Hospital's facilities.

2.1.2 To promote quality professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and through ongoing review and evaluation of each practitioner's performance in the Hospital.

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

2.1.4 To make recommendations to the Governing Body regarding appointment or reappointment to the Medical Staff, and the granting of initial and renewed clinical privileges.

2.1.5 To initiate and maintain Rules and Regulations for self-governance of the Medical Staff.

2.1.6 To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and the Chief Executive Officer.

ARTICLE III
MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

No physician, dentist, or podiatrist, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he or she is a Member of the Medical Staff or has been granted Temporary Privileges in accordance

with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

Only physicians, dentists, podiatrists, and clinical psychologists who 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 quality medical care and who meet the following criteria shall be deemed to possess basic qualifications for membership in the Medical Staff, (except for the Honorary and Retired Staff categories in which case these criteria shall only apply as deemed applicable by the Medical Executive Committee):

(a) They document their (1) current licensure, (2) adequate education, training and experience, (3) current professional competence, (4) good judgment, (5) current adequate physical and mental health status, (6) Drug Enforcement Administration certification, and (7) malpractice liability insurance coverage for the clinical privileges requested, in the coverage amount then established by the Medical Staff and approved by the Governing Body;

(b) They are determined (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, (3) to be able to communicate orally and in writing with Medical Staff members and others who provide patient care, and to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff;

(c) They maintain offices and residences which are located close enough to the Hospital, as determined by the Medical Executive Committee, so as to provide appropriate continuity of quality care for their Hospital patients; and

(d) They maintain a unique physician identification number ("UPIN") and a federal identification number

3.2-2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician membership on the Medical Staff, (except for Honorary Staff), must hold an M.D. or D.O. degree issued by a medical or osteopathic school approved by the Medical Board of California at the time of the issuance of such degree.

(b) Limited License Practitioners.

(1) Dentists. An applicant for dental membership on the Medical Staff, (except for Honorary Staff), must hold a D.D.S. or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.

(2) Podiatrists. An applicant for podiatric membership on the Medical Staff, (except for Honorary Staff), must hold a D.P.M. degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

(3) Clinical psychologists. An applicant for clinical psychology membership on the Medical Staff, (except for Honorary Staff), must hold a PHD degree and a valid and unsuspended certificate to practice clinical psychology issued by the state of California.

3.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to Membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in California or in any other State, is a member of any professional organization, is certified by any clinical board, or had, or presently has, staff membership or privileges at another health care facility. Medical Staff Membership or clinical privileges shall not be conditioned upon or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, hospital -sponsored foundation, other organization or in contracts with a third party which contracts with this hospital.

3.4 NONDISCRIMINATION

Medical Staff Membership or clinical privileges shall not be denied on the basis of sex, race, age, marital status, sexual orientation, ancestry, color, national origin, or physical or mental disability provided such disability that does not pose a direct threat to the quality of patient care.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary Staff, the ongoing responsibilities of each Member of the Medical Staff include, but are limited to:

(a) providing patients with the continuous quality of care that meets the professional standards of the Medical Staff of the Hospital to include professional dress and appropriate identification when performing clinical duties;

(b) abiding by the Medical Staff Bylaws, Rules and Regulations and policies, including, but not limited to, the standards of conduct set forth in Section 3.6 below;

(c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff Membership, including committee assignments;

(d) preparing and completing, in a timely fashion, medical records for all patients to whom the member provides care in the hospital;

(e) abiding by the current ethical principles of the respective professional organizations such as the California Medical Association, the California Dental Association, or the California Podiatric Medical Association, as applicable;

(f) abiding by Hospital policies and procedures and working cooperatively with members, nurses, Hospital administration and others so as not to adversely affect patient care;

(g) making appropriate arrangements for coverage for one's patients as determined by the Medical Staff;

(h) refusing to engage in improper inducements for patient referral as determined by the Medical Staff;

(i) participating in continuing education programs as determined by the Medical Staff or the Service in which one exercises privileges;

(j) participating in such Emergency Service coverage or consultation panels as may be determined by the Medical Staff or the Service in which one exercises privileges;

(k) discharging such other obligations as may be lawfully established from time to time by the Medical Staff, the Medical Executive Committee or the Service in which one exercises privileges;

(l) immediately notifying the Chief of Staff of any action taken, including but not limited to revocation or suspension of one's license and/or DEA certificate or imposition of probation; limitation of practice by, any State, including, but not limited to any action taken against his privileges, to suspension or loss of membership at any hospital or health care facility; or notification of a malpractice judgment or settlement reportable to the Medical Board of California;

(m) serving on a peer review committee including, but not limited to

investigatory and judicial review committees; providing information to and/or testifying on behalf of the Medical Staff or on behalf of an accused practitioner regarding any matter under investigation pursuant to Section (8.1-3 no such section) and any matter which is the subject of a hearing pursuant to Article IX.

3.6 STANDARD OF CONDUCT

Members are expected to adhere to the Medical Staff Standards of Conduct, including, but not limited to, the following:

(a) It is the policy of the Medical Staff to require that its Members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction, conduct and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty and fair dealing with each other, and to promoting a caring and collaborative environment for patients, practitioners, employees and advisors.

(b) Rude, combative and/or obstreperous behavior, as well as willful refusal to appropriately communicate or comply with the rules of the Medical Staff and the Hospital may be determined to be disruptive or unprofessional behavior. It is specifically recognized that patient care and Hospital operations can be adversely affected whenever any of the foregoing behaviors occurs with respect to interactions any where in the Hospital, in that all Members of the organization play an important part in the ultimate mission of delivering quality patient care.

(c) In assessing whether particular circumstances in fact are affecting quality patient care or Hospital operations, the assessment need not be limited to care of specific patients or to direct impact on patient health. Rather, it is understood that quality patient care embraces – in addition to medical outcome – matters such as timeliness of service, appropriateness of service, timely and thorough communications with patients, their families, and their insurers (or third party payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

(d) Upon being granted into a Medical Staff Membership and/or privileges at the Hospital, the Member enters common goal with all Members of the organization to endeavor to maintain quality of patient care and appropriate professional conduct.

(e) Members of the Medical Staff are expected to behave in a professional manner at all times and in all interactions with – patients, professional peers, Hospital staff Hospital personnel,

Members of the organization visitors, and other persons in and affiliated with the Hospital.

(f) Interactions with all persons shall be conducted with courtesy, respect, civility and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with all other persons in and affiliated with the Hospital.

(g) Complaints and/or disagreements of any nature shall be aired constructively, in a nondemeaning, professional and respectful manner through constructive and appropriate channels.

(h) Cooperation and adherence to the rules of the Hospital and the Medical Staff is required.

(i) Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.

3.7 HARASSMENT PROHIBITED

Harassment by a Medical Staff Member against any individual (e.g., another Medical Staff Member, a Hospital employee, a patient, a patient's family, visitors, or vendors) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation shall not be tolerated.

"Sexual harassment" is defined as unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, posters or comments).

"Sexual harassment" includes unwelcome advances, requests for sexual favors, and any other verbal, visual or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. "Sexual harassment" also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence to sexual activities.

Any and all allegations of sexual harassment immediately shall be investigated by the Medical Staff. If confirmed, will result in appropriate corrective action from a formal reprimand up to and including termination of Medical Staff Membership and privileges. The level of corrective action shall be determined by the facts.

3.8 EXCLUSIVE CONTRACTS/INDEPENDENT CONTRACTORS

(a) A Practitioner with whom the Hospital contracts to provide services which involve clinical duties or privileges must be a Member of the Medical Staff achieving one's status by the procedures described in these Bylaws. Unless a contract or agreement executed after this provision is adopted provides otherwise, or unless otherwise required by law, the Membership and Privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the "Review, Hearing, and Appeal" procedures of Articles VIII and IX of these Bylaws, upon termination or expiration of such contract or agreement with the Hospital. Medical Staff Membership or privileges which would otherwise exist independent of the exclusive contract are not to be effected by the termination of the contract. In the event limitation or termination of the contract is for a medical disciplinary cause or reason as defined by Section 9.2, the Practitioner will be entitled to the procedural rights of Article IX.

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

(c) Practitioners who subcontract with Practitioners contracted with the Hospital under an exclusive contract may lose Membership and Privileges granted pursuant to an exclusive or semi-exclusive arrangement without the right of access to the review, hearing, and appeal procedures of Articles VIII and IX of these Bylaws if their relationship with the contracting Practitioner is terminated, or the Hospital and the contracting Practitioner's agreement or exclusive relationship is terminated. The Hospital may enforce such an automatic termination even if the subcontractor's agreement fails to recognize this right. Medical Staff Membership or privileges which would otherwise exist independent of the exclusive contract are not to be effected by the termination of either contract. In the event limitation or termination of privileges is for a medical disciplinary cause or reason as defined by Section 9.2, the Practitioner will be entitled to the procedural rights of Article IX.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall be divided into Active, Courtesy, Consulting, Associate, Honorary or Retired, Telemedicine, and Provisional categories. At appointment and each time of reappointment, the Member's staff category shall be determined. Except for Members of the Honorary or Retired Staff categories,

Members of all staff categories must carry adequate levels of medical malpractice insurance. Only members of the Active Staff and Provisional Staff members who are pending active appointment, shall be required to take Emergency Room calls as set forth herein.

Except for the category of Honorary Staff, Members in all Medical Staff categories will be assessed and shall pay any and all application or re-application fees and annual dues. The Medical Executive Committee will establish the amount of such dues.

4.2 RESPONSIBILITIES AND PREROGATIVES

(a) The responsibilities and prerogatives of each category of Medical Staff Member shall be as set forth in the following chart and as further described in this Article IV.

		Active Staff	Courtesy Staff	Consulting Staff	Associate Staff	Honorary/ Retired Staff	Telemedicine Affil.	Provisional Staff[1]
PREROGATIVES	May Admit Patients	YES	YES	NO	NO	NO	NO	YES
	Clinical Privileges	YES	YES	YES	YES	NO	YES	YES
	Vote	YES	NO	NO	YES	NO	NO	NO
	Hold Office	YES	NO	NO	YES	NO	NO	NO
	Serve as Committee Chair	YES	NO	NO	YES	NO	NO	NO
	Serve on Committee	YES	YES	YES	YES	YES	YES	YES
RESPONSIBILITIES	Medical Staff Functions	YES	YES	YES	YES	NO	YES	YES
	Attend Meetings	YES	YES	YES	YES	NO	YES	YES
	Pay Dues	YES	YES	YES	YES	NO	YES	YES
	Pay Application /Reapplication Fees	YES	YES	YES	YES	NO	YES	YES

	ER Call	YES	NO	NO	NO	NO	NO	YES[2]
OTHER RQMTS	Must first complete Provisional	YES	YES	YES	YES	NO	YES	N/A
	Malpractice Insurance	YES	YES	YES	YES	NO	YES	YES

(b) A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

4.3 ACTIVE STAFF

4.3-1 QUALIFICATIONS

The Active Staff shall consist of physicians, dentists, podiatrists and the clinical psychologists who:

(a) have satisfactorily completed their proctoring requirements and have been a Member in good standing (Provisional status) for a least one year;

(b) regularly admit or are otherwise involved in the care of at least twenty (20) patients per year in this Hospital, except that this requirement shall not apply to physicians, dentists and podiatrists who serve the Hospital in a medico-administrative capacity;

(c) have offices or residences which, in the opinion of the Medical Executive Committee, are located close enough to the Hospital to allow provision of continuous care to their patients or who have made other appropriate arrangements for coverage;

(d) assume all the functions and responsibilities of Membership on the Active Staff, including, where appropriate, Emergency Service care and consultation assignments, except as provided in Section 4.12 below; and

---

(e) meet the general qualifications set forth in Section 3.2 of these Bylaws.

4.3-2 PREROGATIVES/RESPONSIBILITIES

Except as otherwise provided, the prerogatives of an Active Medical Staff Member shall be to:

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article VI and VII.

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

(c) hold Medical Staff, Service, or Service subsection office and serve as a voting member or chair of committees to which the member is duly appointed or elected by the Medical Staff or a duly authorized representative thereof, so long as the activities required by the position fall within the Member's scope of practice as authorized by law.

4.3-3 TRANSFER OF ACTIVE STAFF MEMBER

After one consecutive calendar year in which a Member of the Active Staff fails to regularly care for the minimum required number of patients for the respective category in this Hospital or be regularly involved in Medical Staff functions as determined by the Medical Staff and per the Bylaws, such Member may be automatically transferred to the appropriate category, if any, for which the Member is qualified. In the surgical specialties, a Member may be automatically transferred to the appropriate category if that member performs fewer than twenty (20) surgical procedures in one (1) year. However, in the event that a Member in a surgical specialty is appointed to a new category as a result of failing to perform at least twenty (20) surgical procedures in one (1) calendar year, once the individual performs twenty (20) surgical procedures in one (1) calendar year, that Member will be automatically reappointed to the appropriate category of Medical Staff that the individual held previous to such change.

4.4 COURTESY MEDICAL STAFF

4.4-1 QUALIFICATIONS

The Courtesy Staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who:

(a) has satisfactorily completed proctoring requirements and has been

a Member in good standing (Provisional status) for at least one year;

(b) meets the qualifications for Medical Staff Membership set forth in Article III of these Bylaws;

(c) meets the general qualifications set forth in of Section 3.2.1.

(d) are Members of the Active Staff of another hospital licensed by California, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

(e) have not had more than twenty (20) patient contacts, defined as admissions and consultations, at the Hospital within the past twelve (12) months.

4.4-2 PREROGATIVES/RESPONSIBILITIES

(a) Courtesy Staff Members shall not be eligible to vote or hold office in this Medical Staff organization.

(b) Courtesy Staff Members may admit patients to the Hospital within the limitations of this Section 4.4 and exercise such clinical privileges as are granted pursuant to Article VII.

(c) Courtesy Staff Members may attend meetings of the Medical Staff and the Service of which one is a Member including open committee meetings and educational programs, but such Member shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment, nor have the right to serve on a Committee or as Committee Chair.

4.5 CONSULTING MEDICAL STAFF

4.5-1 QUALIFICATIONS

The Consulting Staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who are Members of the Medical Staff in good standing who may consult in his/her area of expertise. The Consulting Staff Member

(a) have satisfactorily completed proctoring requirements and have been a Member in good standing (Provisional status) for at least one year;

(b) not otherwise be a Member of another category of the Medical Staff but who meets the general qualifications set forth in Article III of

these Bylaws. This requirement shall not preclude an out-of-state Practitioner from appointment as may be permitted by law if that Practitioner is otherwise deemed qualified by the Medical Executive Committee;

(c) possess adequate clinical and professional expertise;

(d) be a Member of the Active Staff of another hospital licensed by California, or any other state, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

(e) be willing and able to come to the Hospital on schedule or to promptly respond when called to render clinical services within one's area of competence and expertise.

4.5-2 PREROGATIVES/RESPONSIBILITIES

The Consulting Staff Member:

(a) shall be entitled to exercise such clinical privileges as are granted pursuant to Article VII;

(b) may serve on Committees, but shall not be eligible to admit patients, serve as Committee Chair, vote, or hold office in the Medical Staff organization;

(c) may attend meetings of the Medical Staff and the Service of which one is a Member including open Committee meetings and educational programs, but shall have no right to vote at such meetings, except within Committees when the right to vote is specified at the time of appointment; and

(d) must meet the proctoring requirements set forth in these Bylaws and in the General and Service Rules and Regulations.

4.6 ASSOCIATE MEDICAL STAFF

4.6-1 QUALIFICATIONS

The Associate Staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who:

(a) meet the qualifications set forth in subsections (a)-(d) of Section 3.2-1; and

(b) provide staff coverage for patients requiring emergency medical services.

4.6-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an Associate Staff Member shall be to:

(a) exercise such clinical privileges as are granted pursuant to Article VII;

(b) serve on Committees; serve as Committee Chair, vote, and hold office in a Medical Staff organization.

4.7 HONORARY AND RETIRED MEDICAL STAFF

4.7-1 QUALIFICATIONS

The Honorary Staff shall consist of physicians, dentists, podiatrists and clinical psychologists who:

(a) are not active in the Hospital, but who are deemed deserving of Membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct.

The Retired Staff shall consist of physicians, dentists, podiatrists and clinical psychologists who:

(a) have retired from active practice and at the time of their retirement, were Members in good standing of the Active Staff for a period of at least ten (10) contiguous years at the Hospital and

(b) who continue to adhere to appropriate professional and ethical standards.

4.7-2 PREROGATIVES/RESPONSIBILITIES

Honorary and Retired Medical Staff Members shall not be eligible to exercise clinical privileges, admit patients, vote, hold office, or serve as Committee Chair on any Medical Staff Committees. Honorary and Retired Members shall be eligible to serve on Medical Staff Committees and may attend meetings of the Medical Staff and participate in Medical Staff functions.

4.8 TELEMEDICINE AFFILIATE STAFF

4.8-1 EXPLANATION: Due to the uniqueness of such Affiliate Practitioners, the following definitions are provided:

4.8-2 DEFINITIONS

(a) Distant Site: the location at which the telemedicine equipment is located and from which the Telemedicine Affiliate Staff Member delivers his/her patient care services.

(b) Originating site: the location at which the patient is located.

(c) Telemedicine Affiliate Staff Member: the individual provider who uses the telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Affiliate Staff Member is generally a physician, but may also be other healthcare professionals involved as Telemedicine providers. The Telemedicine provider would generally contract with (or in the case of non-physicians, be employed by) the entity that serves as the Distant Site.

4.8-3 PREROGATIVES AND LIMITATIONS

(d) The Telemedicine Affiliate Staff shall consist of physicians or other health care professionals who are not otherwise members of the Medical Staff but who participate in telemedicine interactions involving Hospital patients.

(e) Except as next provided, telemedicine interactions are defined as interactive (involving real time [synchronous] or near real time [asynchronous] two-way transfer of medical data and information) audio, video, or data communications, and may include consultations, diagnoses, treatments, transfers of medical data and medical education.

(f) Telemedicine interactions exclude interactions in which the patient is not directly involved, such as informal consultations between physicians or other health care professionals, as well as telephone or electronic mail communications between such persons and the patient.

(g) Telemedicine Affiliate Staff may exercise limited Hospital privileges including limited consulting. They may also serve on a Medical Staff Committee and attend Medical Staff and department meetings, including open committee meetings and educational programs.

(h) Telemedicine Affiliate Staff shall not be eligible to vote, to hold office in a Medical Staff organization, or to serve as a Committee Chair.

(i) Telemedicine Affiliate Staff may not give orders and may not admit

patients to the Hospital or have ultimate authority over the care or primary diagnosis of a Hospital patient.

4.9 PROVISIONAL STATUS

4.9-1 DEFINITION - Except Honorary and Retired Staff Members, all applicants, upon initial appointment to any category of the Medical Staff, shall be assigned Provisional status. The following guidelines shall be followed with respect to Provisional Status:

(a) All initial appointments to any category (except Honorary, Retired or Telemedicine) of the Medical Staff shall remain Provisional for a minimum period of six months.

(b) Provisional Staff Members shall be observed by the Chief of Service or his/her designee as described in Section 7.3, to determine the eligibility of such Provisional Staff Member for regular staff membership and for exercising the clinical privileges provisionally granted to him/her. Provisional Staff Members must also demonstrate cooperative and harmonious relationships with Members of the Medical Staff and Hospital personnel. Progression to apply for staff status may be denied or provisional status terminated on the basis of an inadequate clinical competence and not meeting standards of conduct. See Section 3.6

(c) The Chief of Service or his/her designee shall submit reports of the appointee's clinical performance and qualifications for Membership to the appropriate Service Committee for review and evaluation. Based on these reports, the Service Committee will make a recommendation regarding progression to apply for status to the appropriate Service. The Service Committee shall forward a recommendation regarding progression to apply for status to the Medical Executive Committee for approval by the Governing Body.

(d) Provisional status may be extended for additional six month periods, up to a total of twenty four (24) months at which time the failure to advance an appointee from Provisional to regular staff status may be deemed a termination of his/her Provisional staff appointment. A Provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a Member of the Medical Staff who has failed to be reappointed.

(e) The Provisional Staff Member shall be entitled to:

(i) admit patients and exercise such clinical privileges as are granted pursuant to Article VII; and

(ii) attend meetings of the Medical Staff and the department of

which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

(f) Provisional Staff Members shall not be eligible to hold office in the Medical Staff organization, but may serve upon committees.

4.10 CHANGE IN STAFF CATEGORY

Any Member of the Medical Staff may request a change in Staff Category by submitting such request in writing to the Medical Executive Committee. The Medical Executive Committee shall make a recommendation on the request to the Governing Body, which shall thereafter act upon the request in accordance with Section 6.5-8 of these Bylaws. The recommendation by the Medical Executive Committee shall be based upon the number of patient encounters by the applicant in the twelve months preceding the request for a change in Staff Category.

4.11 LIMITATION OF PREROGATIVES

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

4.12 EMERGENCY ON-CALL PANEL

All Members of the Active Staff are required to participate in the Emergency On-Call Panel. Mandatory Emergency On-Call participation may apply to other categories of Medical Staff Membership at the discretion of the Medical Executive Committee. Notwithstanding the foregoing, Active Staff Members, except Members who practice in a "Scarce Specialty," upon reaching the age of sixty two (62) or having completed thirty (30) years of active service on the Medical Staff shall be eligible to be relieved of mandatory Emergency Department call. The term "Scarce Specialty" shall mean any specialty designated as such by the Medical Executive Committee in their sole and absolute discretion. The physician requesting removal from the mandatory Emergency Department call panel will submit their request pursuant to Item 8 of the General Rules and Regulations of the Medical Staff. In the event that there is only one (1) Member in a specialty, that Member shall be required to participate in the Emergency On-Call Panel for seven (7) days per month or as determined by the Medical Executive Committee.

ARTICLE V
ALLIED HEALTH PROFESSIONALS

5.1 DEFINITIONS

A. “Allied Health Professional (AHP)” means a health care professional, other than a physician, dentist, podiatrist, or clinical psychologist who holds a license or other credential, as required by California law, to provide certain professional services. AHP’s are ineligible for Medical Staff Membership.

B. In lieu of privileges “Service authorization” means the permission granted to all Allied Health Professionals to provide specified patient care services within his or her qualifications and scope of practice.

5.2 QUALIFICATIONS

Allied Health Professionals shall consist of qualified personnel, (other than licensed physicians, dentists, podiatrists, or clinical psychologists), who exercise independent judgment within the area of their professional competence, who are qualified to render direct or indirect patient care under the supervision of Medical Staff Members, who have been accorded practice privileges to provide such care, and who hold a license or certification or are trained in a profession which has been identified by the Medical Executive Committee and the Governing Body as a qualification for applying for practice privileges at the Hospital. This category may include, but is not limited to physician assistants, nurse practitioners, nurse midwives, and certified registered nurse anesthetists. The Medical Executive Committee in its discretion reserves the right to establish additional qualifications required of a specific category of Allied Health Professionals.

Allied Health Professionals shall:

(a) continuously meet and satisfy the basic qualifications and responsibilities required by Sections 3.2 and 3.5 for Medical Staff Members, as applicable to Allied Health Professionals;

(b) hold all licenses and certifications required by law in order to engage in their respective profession;

(c) be professionally qualified to provide services that need to be provided at the Hospital as such need is determined to exist from time to time by the Governing Body and for which the Hospital is licensed to provide;

(d) provide services in one or more of the areas of patient care which the Hospital is equipped, staffed and licensed to offer to patients;

(e) have offices or residences which, in the opinion of the Medical Executive Committee, are located close enough to the Hospital to allow provision of continuous care to one’s patients; and

(f) comply with the provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital policies as.

5.3 PROCEDURE FOR APPOINTMENT AND DELINEATION OF PRACTICE PRIVILEGES

Applications for appointment and reappointment shall be submitted and processed in the same manner as provided in Articles VI and VII for Medical Staff Membership. Allied Health Professionals shall be individually assigned to the Service(s) appropriate to their professional training and shall be subject in general to the same terms and conditions as specified in Section 3.5 and Article VI. Allied Health Professionals shall carry out their professional duties under the supervision of the Chief of the Service and/or his/her designee, subject to Service policies and procedures and in conformance with the applicable provisions of the Medical Staff Bylaws, Rules and Regulations and Hospital policies. Corrective action with regard to Allied Health Professionals including termination or suspension of privileges granted shall be accomplished in accordance with Section 9.6-3 of these Bylaws, except as set forth in Section 5.6.

5.4 PREROGATIVES

Allied Health Professionals:

(a) shall provide specified patient care services under the supervision or direction of a Member of the Medical Staff, except as otherwise expressly provided by resolution of the Medical Executive Committee;

(b) may write orders only to the extent recommended by the Medical Executive Committee and approved by the Medical Staff but not beyond the scope of the professional's license, certificate or other legal credential;

(c) may serve on Medical Staff committees or Hospital committees;

(d) may attend meetings of the Medical Staff, the Service to which assigned and Hospital education programs;

(e) may exercise such other prerogatives as shall be accorded to AHP's as a group, or to any specified category of such professionals, by resolution or written policy duly adopted by the Medical Staff. Such prerogatives may include the right to vote on specified matters or to hold defined offices; and

(f) who are either Nurse Practitioners or Physician Assistants may admit or discharge patients, complete patient history and physical

evaluations and order medications if such are countersigned when necessary by the Supervising Physician. Physician Assistants and Nurse Practitioners shall be required to obtain their Supervising Physicians' counter-signature of such procedures and evaluations as set forth in the following chart:

DOCUMENTATION TO BE COUNTERSIGNED BY SUPERVISING PHYSICIAN		
ORDERS	PA	NP
H&P	Yes	No
Medication	Yes	No
Admission	Yes	Yes
Discharge	Yes	Yes

5.5 RESPONSIBILITIES

Allied Health Professionals shall:

(a) assure that all supervision requirements applicable to his or her practice privileges are continuously met by the Supervising Physician;

(b) retain appropriate responsibility within one's area of professional competence for the care and supervision of each patient in the Hospital for whom they are providing services, or arrange through the Supervising Physician Member of the Medical Staff for alternate coverage;

(c) participate as appropriate in in-patient care evaluation studies and other quality reviews required of the Medical staff, and in such other Medical staff functions as may be required from time to time;

(d) participate in such Emergency Service coverage of consultation panels as may be determined by the Medical Staff;

(e) satisfy the requirements for attendance at meetings of the Medical staff and committees of which one is a member; and

(f) participate in peer review, performance improvement, evaluation and monitoring activities required of AHP's and in discharging such other functions as may be required from time to time.

5.6 AUTOMATIC TERMINATION

Action may be taken to terminate an AHP's privileges by the Chief of Service to which he or she is assigned, the Chief of Staff, the Medical Executive Committee, or the Hospital Chief Executive Officer.

An Allied Health Professional's privileges shall automatically terminate, without review pursuant to Section 9.6-3 or any other section of these Bylaws, in the following events:

(a) The Medical Staff Membership of the Supervising Physician is terminated, whether such termination is voluntary or involuntary;

(b) The Supervising Physician no longer agrees to act as the Supervising Physician for any reason, or the relationship between the AHP and the Supervising Physician is otherwise terminated, regardless of the reason thereof; or

(c) The AHP's certification or license expires, is revoked or is suspended.

ARTICLE VI
PROCEDURES FOR REVIEW, APPOINTMENT AND REAPPOINTMENT
(Including Telemedicine Services)

6.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the Hospital in a medical administrative and/or contractual position) shall exercise clinical privileges in the Hospital unless and until, he or she applies for and receives appointment to the Medical Staff or is granted Temporary Privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or in the case of Members of the Honorary Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws, review the general Rules and Regulations and review the applicable Service Rules and Regulations and agrees that throughout any period of Membership he or she will comply with the responsibilities of Medical Staff Membership and with the Bylaws and Rules and Regulations as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

6.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters and of satisfying requests for information in a timely manner. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination, at the applicant's expense. If such examinations are deemed appropriate by the Credentials Committee, the Service(s) in which the applicant seeks to obtain privileges or the Medical Executive Committee, the Credentials Committee, the Service or the MEC may select the examining physician psychiatrist or psychologist.

6.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, (but only after there has been a recommendation from the Medical Staff provided in Section 8.2, or as set forth in Section 8.2-6). The Medical Staff of the Hospital will review each application for Medical Staff Membership and make a recommendation concerning his appointment based on criteria relating to the applicant's quality of medical care and other criteria, which shall be consistently and uniformly applied to all applicant' applying for Medical Staff Membership. The Governing Body will not act on the appointment of any practitioner to the Medical Staff unless the practitioner has been reviewed by the Medical Staff pursuant to the appointment process set forth in these Bylaws and the Medical Executive Committee has made a recommendation concerning the appointment of the applicant, except that if the Medical Executive Committee fails, without good cause, to make a recommendation within eight (8) months from receipt of a complete application, the Governing Body may take such action as it deems appropriate after notifying the Medical Executive Committee.

6.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments and reappointments to the Medical Staff shall be for a period not to exceed (2) years.

6.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

6.5-1 APPLICATION FORM

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

(a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, certificate of ACLS training (if practicing in moderate sedation), and continuing medical education which is related to the clinical privileges requested;

the applicant must supply a current I.D., style 2.5 x 2.5 inch photo of themselves at the time of initial application to the Medical Staff, or if the Medical Staff Office requests an I.D. photo.

(b) references from three (3) of the applicant's peers, who practice in the same specialty and/or are familiar with the applicant's professional ability and current clinical competence, one of whom is familiar with the applicant's ethical character, and one of whom was the Service Chief or Chief of Staff at the applicant's last hospital staff;

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

(d) past or pending professional disciplinary action, including accusations or investigations involving the applicant's licensure or registration (state or district and Drug Enforcement Administration) or the voluntary or involuntary relinquishment of such licensure or registration, licensure limitations or denials by any state, Medical Staff Membership or clinical privileges, denials, voluntary or involuntary relinquishment of Medical Staff Membership, voluntary or involuntary limitations, reductions or loss of clinical privileges at any hospital, and related matters;

(e) The applicant to the Medical Staff must state that his/her health is such that he/she is able to perform the privileges requested. This statement must be evaluated by the chief of service. Should there be a cause for doubt about the practitioner's statement; a second evaluation by a licensed independent practitioner chosen by the Chief of Staff may be required. The statement and evaluation (documentation) must be part of the applicant's credentials file.

(f) information as to whether the applicant maintains professional liability insurance and, if so, the limits of such insurance coverage and the procedures and clinical privileges covered, which must be for the privileges sought to be exercised at the Hospital.

(g) information as whether the applicant has been dropped or denied professional liability insurance.

(h) final judgments or settlements that have been made against the

applicant in professional liability cases or the status of any cases which are pending including an explanation of each case; and

(i) any past, pending or current exclusion from a state or federal health care program.

Each application for initial appointment or reappointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form he or she shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, relevant Service Rules and Regulations, and summaries of other applicable policies relating to clinical practice in the Hospital. Copies of such Bylaws, Rules and Regulations and relevant summaries are available for review by any applicant submitting an application for reappointment.

j) A Medical Staff Member must promptly notify the medical staff of any arrest or conviction for driving under the influence of alcohol or driving with a blood alcohol level in excess of the legal limit.

k) A Medical Staff Member must cooperate fully and promptly whenever requested by the committee or the Medical Executive Committee to undergo a drug or alcohol test or other physical or mental examination for cause.

6.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 6.1, by applying for appointment or reappointment to the Medical Staff, each applicant:

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

(b) authorizes consultation with others who have been associated with him/her and who may have information bearing on his/her competence, ethics, qualifications and performance, and authorizes such individuals and organizations to fully provide all such information;

(c) consents to inspection of records and documents, including medical records, that may be material to an evaluation of his/her qualifications, ethics and ability to carry out the clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

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

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

(f) consents to the disclosure to other hospitals, medical associations, licensing boards, and other similar organizations any information regarding his/her professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

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

(h) pledges to provide for continuous quality care for his/her patients;

(i) pledges to maintain an ethical practice, including but not limited to refraining from illegal inducements for patient referral, providing continuous care of his/her patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised persons;

(j) acknowledges that any material misstatement or omission of information on the Application or reappointment form or in supporting information can result in an adverse recommendation or later revocation of privileges; and

(k) pledges to be bound by the Hospital and Medical Staff Bylaws, Rules and Regulations, and policies.

(l) Any member regardless of category must provide a current mailing address. The Medical Staff will not be held responsible if registered mail is returned as “undeliverable or unclaimed” because the address used was not current.

6.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed, signed and dated application with supporting documentation to the Medical Staff Office along with payment of Medical Staff dues or fees, if required. The Medical Staff Office shall expeditiously seek to collect or verify the references, licensure status, and

other evidence submitted in support of the application, except the verification process shall not be initiated until the fees and all documentation requested by the application, as delineated in Section 6.5-1, has been submitted by the applicant. The Hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant and submit any resulting information to the Service Committee for inclusion in the applicant's credentials file. The applicant shall be notified of any problems in obtaining the information required and it shall be the applicant's obligation to obtain the required information. When collection and verification is accomplished, the application shall be considered complete and all such information shall be transmitted to the Service Committee. No final action on an application may be taken until receipt of the Data Bank Report.

6.5-4 SERVICE ACTION

After receipt of the application, all references and other supporting documentation, and the Credentials Committee report, the Service Chair, designee, or the Service Committee shall review the application, evaluate and verify the supporting documentation and other relevant information, and shall determine whether the applicant has met the qualifications for Membership as established by the Medical Staff Bylaws and the Rules and Regulations of the Medical Staff. The Chair or Service Committee shall review the clinical competence of the applicant to exercise the clinical privileges requested and shall identify any questions concerning the qualifications of the applicant. The Chair of the Service Committee shall instruct the Medical Staff Office to request any additional or clarifying information necessary to resolve any outstanding questions. The Chair or Service Committee may, at its option, interview the applicant.

The Service Chair, on behalf of the Service Committee, shall make a written recommendation to the Medical Executive Committee concerning the appointment, membership category, assignment to a Service, and clinical privileges to be granted to the applicant, along with any restrictions or limitations recommended upon the exercise of such clinical privileges by the applicant. The Service Chair shall forward the recommendation to the Medical Executive Committee with the application and its supporting documentation. If the Service Committee recommends that the Medical Executive Committee defer action on the application or determines that the applicant is not qualified for Medical Staff Membership, the reasons for such recommendation or determination shall be stated.

6.5-5 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application and evaluate and verify the supporting documentation, and other relevant information. The Credentials Committee may elect to interview the applicant and seek

additional or clarifying information. As soon as possible, the Credentials Committee shall transmit to the Service Chairman or Service Committee a report with its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted and any conditions to be attached to the appointment. The Credentials Committee may also recommend that the Service Committee defer action on the application.

6.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the application, all relevant documents and recommendations, or as soon thereafter as is practical, the Medical Executive Committee shall consider the recommendations and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Service Committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee may also defer action on the application. The reasons for each recommendation shall be stated.

6.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be forwarded promptly, together with supporting documentation and a recommendation regarding membership category, Service affiliation, clinical privileges to be granted, and any conditions to be attached to the appointment, to the Chief Executive Officer for prompt transmittal to the Governing Body.

(b) Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Chief Executive Officer and the applicant shall be promptly informed by written notice. In such notice the applicant shall be informed that he or she is entitled to the procedural rights provided in Article IX.

6.5-8 ACTION ON THE APPLICATION

The Governing Body may accept, modify or reject the recommendation of the Medical Executive Committee or it may refer the matter back to the Medical Executive Committee for further consideration, such referral shall state the purpose for such referral and a reasonable time limit for making a subsequent recommendation. The following procedure shall apply with respect to action on the application:

(a) If the Medical Executive Committee issues a favorable recommendation, the Governing Body or its duly appointed committee (in cases eligible for expedited processing) shall affirm

the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence. If the Governing Body concurs in the recommendation, then the decision of the Governing Body shall be deemed a final action. If the tentative final action of the Governing Body is unfavorable, then the Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article IX. If the applicant waives his procedural rights in accordance with Article IX, the decision of the Governing Body shall be deemed a final action. (See Section 6.7-7)

(b) In cases eligible for expedited reinstatement processing, if the duly appointed committee and the Governing Body concur in the recommendation, the favorable recommendation shall be ratified by the Governing Body at its next regularly scheduled meeting. The ratification by the Governing Body shall be deemed final. If the Committee's decision is adverse to the applicant, or the Governing Body fails to ratify the Committee's decision, the matter shall be referred back to the Medical Executive Committee for evaluation.

(c) In the event the recommendation of the Medical Executive Committee, or any significant part of it, is adverse to the applicant, the procedural rights set forth in Article IX shall apply. If the applicant waives his/her procedural rights in accordance with Article IX, the recommendation of the Medical Executive Committee shall become the final action, subject only to action by the Governing Body.

(d) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 6.5-7(b) or an adverse tentative final action of the Governing Body pursuant to Section 6.5-8(a), the Governing Body shall take final action only after the applicant has exhausted his/her procedural rights as established by Article IX. After exhaustion of the procedures set forth in Article IX, the Governing Body shall make a final decision and shall affirm the decision of the Judicial Review Committee in all cases, unless it finds that: (1) the decision was not based on any criteria relating to the applicant's quality of medical care or professional ethics; or (2) the procedural rights of the applicant under Article IX were violated, and so states the reasons for its findings in writing. In determining to affirm the decision of the Judicial Review Committee based on either of the two reasons noted above, the Governing Body shall give great weight to the decision of the Judicial Review Committee and shall not act in an arbitrary or capricious manner.

(e) Applicants are ineligible for expedited reinstatement processing if, at the time of appointment, any of the following has occurred:

(1) the applicant submits an incomplete application;

(2) the Medical Executive Committee makes a final recommendation that is adverse or with limitation;

(3) there is a current challenge or previously successful challenge to licensure;

(4) the applicant has received an involuntary termination of medical staff membership at another organization;

(5) the applicant has received involuntary limitation, reduction, denial, or loss of Medical Staff clinical privileges; or

(6) there has been a final judgment adverse to the applicant in a professional liability action.

6.5-9 NOTICE OF FINAL DECISION

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

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

6.5-10 REAPPLICATION AFTER ADVERSE DECISION

(a) The following Members shall not be eligible to reapply for Medical Staff Membership and/or Clinical Privileges affected by the previous action for a period of at least thirty-six (36) months from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former Medical Staff M ember's resignation became effective, whichever is applicable:

(1) An applicant who has: (a) received a final adverse decision regarding appointment or, (b) withdrawn his application or request for Membership or privileges following an adverse recommendation from Service, the Medical Executive Committee or the Governing Body;

(2) A former Medical Staff Member who has: (a) received a final adverse decision resulting in termination of Medical Staff Membership and clinical privileges or, (b) resigned from the Medical Staff following the issuance of the Service, the Medical Executive Committee or the Governing Body's recommendation adverse to the Member's Medical Staff Membership or clinical privileges; or

(3) A Medical Staff Member who has received a final adverse decision resulting in: (a) termination or restriction of his/her clinical privileges or, (b) denial of his/her request for additional clinical privileges.

(b) For the purposes of this Section 6.5-10, a decision shall be considered to be adverse only if it is based on a medical disciplinary cause or reason as that term is defined by Section 9.2. Actions which are not considered to be based on a medical disciplinary cause or reason include but are not limited to actions based on a failure to pay dues, which can be cured by paying dues. Further, for purposes of this Section 6.5-10, an adverse decision shall be considered final at the time of completion of: (1) hearings, appellate review and other quasi-judicial proceedings conducted by the Medical Staff at the Hospital bearing on the decision; and, (2) all judicial proceedings bearing upon the decision which are filed and served within thirty-six (36) months after the completion of the Hospital proceedings described in Section 6.5-10 (a)(1) above.

(c) After the thirty-six (36) month period, the former applicant, former Medical Staff Member, or Medical Staff Member may submit an application for Medical Staff Membership and/or clinical privileges, which shall be processed as an initial application. The former applicant, former Medical Staff Member, or Medical Staff Member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such applications shall not be processed unless the applicant, former Medical Staff Member or Medical Staff Member submits satisfactory evidence to the Medical Executive Committee that he or she has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The Medical Executive Committee's decision as to whether satisfactory evidence has been submitted shall be final. (Procedures in Article IX shall apply.)

6.5-11 TIMELY PROCESSING OF APPLICATIONS

Applications for Medical Staff appointments shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon in accordance with the following guidelines:

(a) Evaluation, review, and verification of application and all supporting documents by the Medical Staff Office: (30) days from receipt of all required documentation.

(b) Review and recommendation by Credentials Committee: (30) days from receipt of all required documentation.

(c) Evaluation, review, and verification of application and all supporting documents by the Service Committee at the next scheduled meeting, or by the Chief of Service, or designee, following receipt of all required documentation: (30) days from receipt of all required documentation and Credentials Committee recommendation.

(d) Review and recommendation by Medical Executive Committee at the next scheduled meeting following receipt of Service Committee recommendations. Processing the application should be completed within 6 months from receipt of the application: (30) days from receipt of all required documentation and Service Chief's recommendation.

(e) Except in expedited reinstatement cases or in cases where hearings are required, final action shall be taken one hundred eighty (180) days after receipt of all required documentation by the Medical Staff Office. In expedited reinstatement cases, final action shall be taken within thirty (30) days of receipt of all required documentation. (Where hearings are required, final action shall be taken within fourteen (14) days from the conclusion of the hearing.)

The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his application processed in those time periods. [This severely limits MEC even with last paragraph]

6.5-12 EXPEDITED CREDENTIALING APPROVAL PROCESS

To expedite appointment, reappointment and renewal or modification of Clinical Privileges, the Governing Body may delegate the authority to render those decisions to a credentialing committee of the Governing Body. Membership on this committee shall include the Chief of the Clinical Service of the requesting applicant, the Chair of the Credentials Committee, the Chair of the Medical Executive Committee, a member of

the Governing Body, and the Hospital's Chief Executive Officer or the respective designee. This committee shall meet as often as necessary as determined by its members.

Following a favorable determination by the Medical Executive Committee, the credentialing committee will review the qualifications and competence of the Practitioner as evaluated by the Medical Executive Committee and render its decision. A positive confirmation by the credentials committee will result in the status or Privileges requested. The full Governing Body will consider and, as appropriate, ratify all positive credentials committee decisions at its next regularly scheduled meeting.

If a decision of the credentials committee is adverse to an applicant, the matter will be referred back to the Medical Executive Committee for further evaluation.

An applicant may be ineligible for this expedited process if, at the time of his/her application for appointment or reappointment, any of the following has occurred:

(a) Submission of an incomplete application;

(b) A current challenge or prior successful challenge to licensure or registration exists;

(c) Involuntary termination of medical staff membership at another organization;

(d) Involuntary limitation, reduction, denial or loss of Clinical Privileges; or

(e) A final judgment adverse to the applicant in a professional liability action.

6.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STATUS OR PRIVILEGES

6.6-1 APPLICATION FOR REAPPOINTMENT

(a) At least four (4) months prior to the expiration date of the current Medical Staff appointment ("Appointment Expiration Date"), a reapplication form developed by the Medical Executive Committee shall be mailed or delivered to the Member. If an application for reappointment is not received by the Medical Staff Office from the Medical Staff Member at least sixty (60) days prior to the Appointment Expiration Date, a certified letter shall be promptly sent to the reapplicant Medical Staff Member advising that the

application has not been received. At least forty-five (45) days prior to the Appointment Expiration Date, each Medical Staff Member shall submit to the Medical Staff Office the completed application form for renewal of appointment to the Medical Staff, and for renewal or modification of clinical privileges. If a completed application is not received at least forty five (45) days prior to the Appointment Expiration Date, a certified letter shall be sent notifying the reapplicant Medical Staff Member that the failure to provide a completed application has resulted in the voluntary resignation of that Member's Medical Staff appointment pursuant to Section 6.6-5. The timing of the reapplication process is summarized in the following table:

Reapplication Event	Timing
Appointment Expiration Date	**Two (2) years** from the date of the Member's Initial Appointment Date or Reappointment Date.
Reapplication Form Mailed to Member	**Four (4) months** prior to the Appointment Expiration Date.
Notice of Failure to Receive Renewal Application	**Sixty (60) days** prior to the Appointment Expiration Date, the Medical Staff Office will send the Member written notice that the Medical Staff Office has not received the Member's Renewal Application.
Renewal Application Deadline	**Forty-five (45) days** prior to the Appointment Expiration Date. If the Renewal Application is not received by the Renewal Application Deadline, the Member is deemed to have **voluntarily resigned Membership**.

The reapplication form shall include all information necessary to update and evaluate the qualifications of the reapplicant.Upon receipt of the reapplication, the information shall be processed as set forth commencing at Section 6.6-1.

(b) A Medical Staff Member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed, except for good cause, within thirty-six (36) months of the time a similar request has been denied.

The Medical Executive Committee may recommend a change of status at the time of reappointment if it deems the Medical Staff Member has not met the qualifications for one's current status. The

Medical Staff Member will be so notified following the completion of the reappointment process.

6.6-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of Medical Staff status or privileges is the same as that set forth in Section 6.5-2.

6.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a Medical Staff member submits the first application for reappointment, and every two (2) years thereafter, or when the Medical Staff Member submits an application for modification of staff status or clinical privileges, he/she shall be subject to an in-depth review which shall include, without limitation: (i) a review and evaluation of the reapplicant's quality assurance record; (ii) a review and evaluation of the reapplicant's handwriting and use of abbreviations; (iii) the quantity and nature of any Quality Review Reports pertaining to that Medical Staff Member; and, (iv) the reapplicant's previous violations of any standards of conduct set forth in the Bylaws or elsewhere. Such review shall follow the procedures set forth in Section 6.5-3 through 6.5-11.

6.6-4 EXTENSION OF REAPPOINTMENT

Extensions of reappointment are not allowed under any circumstances.

6.6-5 FAILURE TO FILE REAPPOINTMENT APPLICATION

If the Member fails to submit a completed application for reappointment within forty five (45) days prior to the Appointment Expiration Date, the Member shall be deemed to have voluntarily resigned his/her membership in the Medical Staff and that Member's Staff Membership shall be terminated upon expiration of said Members present term. In the event Medical Staff Membership terminates for the reasons set forth in this Section 6.6-5, the procedures set forth in Article IX shall not apply. The Member may apply for expeditious reinstatement according to Article 6.7-7. If a Medical Staff Member's appointment is automatically suspended as a result of his/hers failure to timely complete and return the reappointment application, the Medical Staff Member shall be charged a Five Hundred Dollar ($500.00) application fee upon the Medical Staff Member's subsequent reapplication for reappointment.

6.6-6 NO VOLUME PHYSICIANS

Applicants who have had no clinical activity during the preceding appointment period will receive a certified letter stating that since there was no clinical activity within twenty-four (24) months, the Member will be

deemed a voluntary resignation, unless there is good cause.

6.7 LEAVE OF ABSENCE

6.7-1 LEAVE STATUS

At the discretion of the Medical Executive Committee, a Medical Staff Member may obtain a voluntary leave of absence from the Medical Staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired. Such leave may not exceed two (2) years. During the period of the leave, the Medical Staff Member shall not exercise clinical privileges at the Hospital and Membership rights and responsibilities, including the obligation to pay dues, shall be inactive.

6.7-2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff Member may request reinstatement of privileges by submitting a written notice to the Medical Executive Committee. The Medical Staff Member shall submit a summary of relevant activities during the leave if the Medical Executive Committee so requests.

The Medical Executive Committee, at their sole discretion, shall make a recommendation concerning the reinstatement of the Medical Staff Member's privileges and prerogatives, based on the procedures provided in Sections 6.1 through 6.5-11. The Medical Executive Committee, on case by case basis, may eliminate some of the requirements of Section 6.1 through 6.6-11 based on issues such as whether the practitioner is requesting to return to the exact same category of membership with the same privileges and prerogatives, or the circumstances of the leave taking, or the length of time of his membership on this Medical Staff or any other reason deemed important to the Medical Executive Committee.

6.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement at least thirty days prior to the termination of the leave of absence shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Membership, privileges, and prerogatives. A Medical Staff Member whose Membership is automatically terminated shall be entitled to an interview before the Medical Executive Committee for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable. The decision of the Medical Executive Committee on this question shall be final and the procedures of Article IX shall not apply. A request for Medical Staff Membership subsequently received from a member so terminated shall be submitted and processed

according to Article 6.7-7.

6.7-4 MEDICAL LEAVE OF ABSENCE

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff Member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a “medical leave” which is not granted for a medical disciplinary cause or reason.

6.7-5 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee or its designee. Reactivation of Membership and clinical privileges previously held shall be granted, but may be granted subject to monitoring and/or proctoring as determined appropriate by the Medical Executive Committee.

6.7-6 VOLUNTARY TERMINATION OF MEMBERSHIP AND PRIVILEGES

A Member of the Medical Staff in good standing may, at any time, terminate his or her Medical Staff membership and clinical privileges. Such termination shall be accomplished through submission of a letter of resignation to the Medical Staff Office requesting termination of Medical Staff Membership and Privileges. The termination shall be effective upon receipt of such letter of resignation by the Medical Staff Office and upon receipt by the Medical Staff Office of a notice from the Medical Records Department that the resigning Medical Staff member has completed all medical records. A Medical Staff Member is responsible for assuring continuity of care for any patients for which that Medical Staff Member is responsible at the Hospital subsequent to such voluntary termination of Membership. This section shall not limit the right of the Medical Staff to deem a Medical Staff Member’s resignation as reportable to the Medical Board, the National Practitioner Data Bank or to otherwise limit a practitioner’s Medical Staff Membership or clinical privileges consistent with the provisions of these Bylaws.

6.7-7 REINSTATEMENT TO MEDICAL STAFF

Practitioners who within the past two years were Members of the Medical Staff and whose appointment was terminated for other than disciplinary cause or reasons may be eligible for expedited reinstatement. Expedited reinstatement will be determined at the discretion of the Service Committee which must include:

(a) all portions of regular reappointment process;

(b) conduct information regarding activities during term of absence; and

(c) letters of recommendation.

(d) 1. reapplication fee of $500.00 (five hundred) plus
2. an additional $75.00 (seventy five) fee for expedited processing

ARTICLE VII
CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a Medical Staff Member providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be Hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the Rules and Regulations of the Service and the authority of the Service Chief and the Medical Staff. Medical Staff privileges may be granted, continued, modified, or terminated by the Governing Body of this Hospital only upon a recommendation of the Medical Staff, only for reasons directly related to the quality of patient care and/or other provisions of the Medical Staff Bylaws, and only following the procedures set forth in these Bylaws.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff or for clinical privileges must contain a request for the specific clinical privileges desired by the applicant or reapplicant. A request for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or current experience supportive of the request. Nothing herein is intended to alter or change the time requirements set forth in Section 6.5-10.

7.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the Medical Staff Member's or applicant's education, training, experience, demonstrated professional competence, judgment and ethics, clinical performance, current health status and the documented results of patient

care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, including but not limited to, other institutions and health care settings where a Medical Staff Member or applicant exercises clinical privileges.

7.3 PROCTORING

7.3-1 OBSERVATION OF MEDICAL STAFF MEMBERS

(a) Except for Honorary and Retired Medical Staff Members, each Medical Staff Member shall undergo a period of observation by designated monitors. The purpose of observation shall be to evaluate the Medical Staff Member's: (1) proficiency in the exercise of clinical privileges initially granted; and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of Provisional Medical Staff Members shall follow whatever frequency and format each service or department deems appropriate in order to adequately evaluate the Provisional Medical Staff Member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained by the Medical Staff Office.

(b) Proctoring (FPPE)

(1) Each member in provisional status shall complete such proctoring (Focused Professional Practice Evaluation – FPPE) as may be required by the clinical Service. Proctoring shall be in accordance with criteria set forth in the appropriate Clinical Service Rules and Regulations, and/or the Proctoring Guidelines Policy, and may include direct observation of performance and/or chart review. A Member in provisional status shall remain subject to proctoring until the Service Chief has determined that proctoring has been successfully completed based on Clinical Service criteria. Documentation attesting to such shall be signed by the Service Chief, along with an evaluation of performance, and a statement as to whether the Member meets all of the qualifications and has discharged all of the responsibilities of the category to which he/she was appointed.

(2) Medical Staff Members who change Medical Staff classification to one of the greater clinical responsibility, or who are granted additional privileges, shall also complete a

period of proctoring in accordance with procedures outlined in this Subsection.

Proctoring shall be performed by a Member in good standing of the Medical Staff of San Gorgonio Memorial Hospital, with privileges in the specialty area being proctored. Each Clinical Service shall establish, in its Rules and Regulations, a term of, and process for, proctoring.

If a sufficient amount of clinical activity has not occurred during the provisional period, proctoring may be extended beyond the provisional period from formal request to, and approval by the Service Chief and approval by the Credentials Committee.

If a sufficient amount of clinical activity has not occurred to evaluate a practitioner's ongoing professional competence, the Service Chief may impose proctoring with the concurrence of the Credentials Committee. Such proctoring shall not entitle the practitioner to the procedures set forth in Article IV.

If an initial appointee fails to receive the documentation required in Subsection 4.2 above within the proctoring term, his/her Medical Stall Membership or particular clinical privileges, as applicable, may be terminated. If a Medical Staff Member requesting additional privileges fails, within the proctoring term, to receive the documentation required in Subsection 4.2 above, the additional privileges may be terminated. The chief of Staff shall give the Staff Member so affected written notice that he/she had a right to request a hearing pursuant to Section 9.3-2 below. Thereafter the procedures set forth in Article IV shall be followed unless the failure to receive the documentation required in Subsection 4.2 above was because of a failure to have a sufficient number of cases proctored because of limited clinical activity.

7.3-2 FAILURE TO OBTAIN CERTIFICATION

If a member fails, within the time of Provisional Medical Staff Membership, to furnish the certification required for specific clinical privileges, or if a Medical Staff Member, exercising new clinical privileges fails to furnish such certification within the time allowed by the Service, those specific

clinical privileges shall automatically terminate. If this occurs the Medical Staff Member shall be entitled to a hearing, upon request, pursuant to Article IX. However, the only issue to be resolved at such hearing is whether the Medical Staff Member timely provided such certification.

7.3-3 MEDICAL STAFF ADVANCEMENT

The failure to obtain certification for any specific clinical privilege shall not, of itself, preclude advancement in a Medical Staff category of any Member. If such advancement is granted absent such certification, continued proctoring of the uncertified procedure shall continue for the specified time period.

7.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

7.4-1 ADMISSIONS

(a) Except as provided by subdivision (b), dentists, oral maxillofacial surgeons, clinical psychologists and podiatrists who are members of the Medical Staff may only admit patients if a physician Member of the Medical Staff performs the admitting history and physical examination (except the portion related to dentistry or podiatry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

(b) Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and who have been determined by the Medical Staff to be competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo the surgical procedures the oral and maxillofacial surgeon proposes to perform. Completion of a history and physical by a qualified oral and maxillofacial surgeon under this subsection (b) shall satisfy the appraisal portion of the requirements of Section 7.4-3 below. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician Member of the Medical Staff must conduct or directly supervise the admitting history and physical examination, (except the portion related to oral and maxillofacial surgery), and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

7.4-2 SURGERY

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

7.4-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist, oral and maxillofacial surgeon or podiatrist shall receive the same basic medical appraisal as patients admitted to other Services, and they shall seek consultation with a physician Medical Staff Member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Where a dispute exists regarding proposed treatment between a physician Medical Staff Member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Service(s).

7.5 TEMPORARY CLINICAL PRIVILEGES

Temporary Clinical Privileges are allowed under two circumstances only: (i) to fulfill an important patient care need or, (ii) to allow a practitioner to exercise his/her privileges pending formal approval by the governing body. The granting of Temporary Privileges does not entitle one to Membership in the Medical Staff.

7.5-1 CIRCUMSTANCES

(a) Temporary Clinical Privileges for Applicants:

Temporary Privileges may only be granted by the Chief of the Medical Staff and the Chief Executive Officer or their authorized respective designees, and on a case by case basis.

Temporary Clinical Privileges shall not routinely be granted to applicants. In extraordinary situations when necessary to avoid undue hardship to the applicant and the applicant's patient(s), the Chief Executive Officer, after receipt of a completed application for Medical Staff appointment (to include but not limited to 1. Current professional licensure verified from the primary source in the State 2. Current Drug Enforcement (DEA) number if the practitioner prescribes or furnishes medications 3. Results of a National Practitioner Data Bank (NPDB) query) and specific clinical privileges, and upon the approval of the Chief of Staff, may grant Temporary Clinical Privileges to an applicant for a specific time period not to exceed one hundred and twenty (120) days in a calendar year. Extensions of temporary clinical privileges may be

granted as approved by the Credentials Committee in cases where unforeseen circumstances prevent timely final approval of the application.

(b) Temporary Clinical Privileges for Non-Applicants:

Temporary Clinical Privileges may be granted where good cause exists to allow a physician to provide care to a specific patient (not more than two (2) specific patients during a calendar year), provided that the procedure described in Section 7.5-3 has been completed.

Temporary Clinical Privileges for the care of specific patients or serving as a Locum Tenens for a current Member of the Medical Staff may be granted by the Chief Executive Officer, upon the recommendation of both the appropriate Chief of Service as well as the Chief of Staff, to an individual who is not an applicant for appointment, provided that no Temporary Clinical Privileges will be recommended or granted until adequate information about the applicant's education, training, experience, malpractice insurance and licensure has been obtained and confirmed, as appropriate. Such individual's signed acknowledgment to be bound by the Medical Staff Bylaws, Rules and Regulations and policies must also be obtained. Such Temporary Clinical Privileges shall be restricted to the specific patient(s) for which they are granted or for the Locum Tenens coverage of a specific Medical Staff Member.

Temporary Clinical Privileges for non-applicants are granted at the discretion of the Service Chief, Chief Executive Officer and the Chief of Staff. Out of state practitioners granted Temporary Consulting Privileges within the limitations of California Business and Professions Code Section 2060 are subject to its provisions. One-time Temporary Clinical Privileges shall not ordinarily be granted unless there is no appropriately credentialed Medical Staff Member available for the given care situation.

7.5-2 APPLICATION AND REVIEW

Temporary Privileges may be granted only when the applicant has submitted a completed application for Medical Staff Membership or a written request for Temporary Privileges and the information available evidences the applicant appears to have the license, training, qualifications, ability and judgment required by Section 3.2-l.

7.5-3 GENERAL CONDITIONS

(a) If granted Temporary Privileges, the applicant shall act under the supervision of the Service Chief to which the practitioner has been assigned, and shall ensure that the Chief, or the Chief's designee, is kept closely informed as to his/her activities within the Hospital.

(b) Temporary Privileges shall automatically terminate at the end of the designated period unless earlier terminated in accordance with Section 7.5-4 or unless affirmatively renewed following the procedure set forth in Section 7.5-1.

(c) Requirements for proctoring including but not limited to those in Section 7.3, shall be imposed on such terms as may be appropriate under the circumstances upon any practitioner granted Temporary Privileges by the Chief of Staff in consultation with the Service Chief, or the Service Chief's designee.

(d) All persons requesting or receiving Temporary Privileges shall be bound by the Bylaws and Rules and Regulations of the Medical Staff, including but not limited to the requirement of Section 3.2-I(a) regarding professional liability insurance.

7.5-4 TERMINATION

Whenever failure to take immediate action against a practitioner with Temporary Privileges may result in imminent danger to the health or safety of any person, the Chief of Staff, the Chief of the Service under which the practitioner holds the Temporary Privileges, or the Chief Executive Officer may summarily suspend the practitioner in accordance with Section 8.3, and assign a Member of the Medical Staff acceptable to the patient to assume responsibility for the care of such patient(s) until the patient is discharged from the Hospital.

7.5-5 RIGHTS OF THE PRACTITIONER

A practitioner shall not be entitled to the procedural rights afforded by Article IX Hearing and Appellate Reviews because his or her request for Temporary Privileges is refused or because any or all of his or her Temporary Privileges are modified, suspended, or terminated, unless such action is taken for medical disciplinary cause of reason.

7.6 EMERGENCY PRIVILEGES

(a) In the case of an emergency, any Member of the Medical Staff or other person exercising clinical privileges, to the degree permitted by his/her license and regardless of Service, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The Member or other

person exercising clinical privileges shall make every reasonable effort to communicate promptly with the Service Chief concerning the need for emergency care and assistance by Members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the Service Chief with respect to further care of the patient at the Hospital.

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

(c) In the case of a disaster in which the Emergency Management Plan has been activated and the Hospital is unable to handle the immediate patient needs, the Chief of Staff, or in the absence of the Chief of Staff, the Chief of Staff Elect, may grant Emergency Privileges. In the absence of the Chief of Staff, the Chief of Staff Elect, the Past Chief of Staff, the Treasurer of the Medical Staff, and the Service Chiefs, the Chief Executive Officer or the CEO's designee of the Hospital may grant the Emergency Privileges of this subsection. If the CEO or the CEO's designee grants Privileges under this sub-paragraph, such grant of Privileges must be ratified by an Active Member of the Medical Staff. The grant of Privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to Grant such privileges.

(d) The verification process of the credentials and privileges of individuals who receive Emergency Privileges under this subsection shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:

(1) The Medical Staff identifies in writing the individual(s) responsible for granting Emergency Privileges.

(2) The Medical Staff describes in writing the responsibilities of the individual(s) responsible for granting Emergency Privileges. There is a mechanism to allow staff to readily identify these individuals.

(3) The Medical Staff addresses the verification process as a high priority. The Medical Staff has a mechanism to ensure that the verification process of the credentials and privileges of the individuals who receive Emergency Privileges begins as soon as the immediate situation is under control. This privileging process is identical to the process established under the Medical Staff Bylaws for granting Temporary Privileges to fulfill an important patient care need. [See (d) on page 43]

(4) The Chief Executive Officer and the Chief of Staff or his/her designee(s) may grant Emergency Privileges upon presentation of any of the following:

(i) A current picture Hospital ID card.

(ii) A current license to practice and a valid ID issued by a state, federal, or regulatory agency.

(iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) (i.e., FEMA, or state or local health offices).

(iv) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.

(e) Persons granted Disaster Privileges shall wear identification badges denoting their status as a DMAT Member.

(f) The Medical Staff shall begin the process of verification of Credentials and Privileges as soon as the immediate situation is under control.

(g) The responsible Service Chain shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted Disaster Privileges.

7.7 MODIFICATION OF CLINICAL PRIVILEGES OR SERVICE ASSIGNMENT

Upon consultation with a Service, or pursuant to a request under Section 6.6-1(b), the Medical Executive Committee may recommend a change in the clinical privileges or service assignment(s) of a Member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff Member be made subject to monitoring in accordance with procedures similar to those outlined in Section 7.3-1.

7.8 LAPSE OF APPLICATION

If a Medical Staff Member requesting a modification of clinical privileges or Service assignments fails to timely furnish the information necessary to evaluate the request, the request shall automatically lapse after twelve (12) months, and the applicant shall not be entitled to a hearing as set forth in Article IX.

ARTICLE VIII
CORRECTIVE ACTION

8.1 OVERVIEW

8.1-1 GOALS

The Medical Staff is responsible for overseeing the quality of medical care, treatment, and services delivered in the Hospital. An important component of that responsibility is the oversight of care rendered by Members practicing in the Hospital. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible. However, when circumstances warrant, the Medical Staff is responsible to embark on informal remedial measures and/or corrective action as necessary to achieve and assure quality of care, treatment and services.

Members of the Medical Staff are expected to actively participate in the Hospital's quality improvement activities. Peer review is an important component of such activities. The primary goals of peer review are to prevent, detect, and resolve problems and potential problems. The responsibility for peer review is delegated to the Medical Staff. Medical Staff Members are responsible to carry out delegated peer review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, and useful.

8.1-2 PARTICIPATION AND PEER REVIEW

The Medical Staff Officers, Sections and Committees are responsible for carrying-out delegated peer review and quality improvement functions in accordance with the procedures set forth in the General Rules and Regulations of the Medical Staff. Whenever feasible in the context of "Peer Review," the term "Peer" will be interpreted to mean that a majority of the principle reviewers (i.e., the reviewers initially responsible to assess standard of care for that category of practitioner) will hold the same license as the practitioner under review, and at least one of the reviewers will practice the same specialty as the practitioner under review. Where this is not feasible, given the size and composition of the Medical Staff, reasonable efforts should be made to consult with one or more peers not on the Medical Staff to obtain reliable information as to the appropriate standard of care applicable to the involved category of the practitioner (also see Section 12.14).

8.2 CORRECTIVE ACTION

8.2-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff or a Service about the conduct, performance or competence of its Members. When reliable information indicates a Member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) unethical; (2) detrimental to patient safety or to the delivery of quality patient care within the

Hospital; (3) contrary to the Medical Staff Bylaws and Medical Staff Rules and Regulations; or (4) below applicable professional standards, a request for an investigation or action (through use of a Quality Review Report or otherwise) against such Member may be initiated by the Chairman of the Physician Well Being Committee, the Performance Improvement Officer, the Chief of Staff, a Service Chief, the Peer Review Committee, the Chief Executive Officer or the Medical Executive Committee.

(a) Informal Corrective Actions

The Medical staff officers, services and committees may counsel, educate, issue letters of warning or censure, or focused professional practice evaluation in accordance with the Bylaws and according to the qualifications mentioned in Title XXII, in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The Member shall be given an opportunity to respond in writing and may be given an opportunity to meet with the officer, service or committee. Any formal actions, monitoring or counseling shall be documented in the Member's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of privileges or grounds for a formal hearing or appeal rights under Bylaws dealing with Hearings and Appellant Reviews.

8.2-2 INITIATION

A request for an investigation must be in writing, submitted to either the Medical Executive Committee or a Service, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recordation of the reasons.

8.2-3 INVESTIGATION

The Chair of the Physician Well Being Committee shall conduct an initial screening of any request for investigation as set forth in Section 8.2-1 above. Upon receipt of the request for investigation, the Chair of the Physician Well Being Committee shall notify the Medical Staff Member that the report has been issued. The Chair of the Physician Well Being Committee shall, whichever the case may be, determine whether further action shall be required in consultation with the Chief of Staff, a Service Chief, the Chief Executive Officer or the Medical Executive Committee. If it is determined that an investigation is warranted, the Medical Executive Committee shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign

the task to an appropriate Medical Staff Officer, Medical Staff Service, standing or ad hoc committee of the Medical Staff or other reviewing body as determined by the Medical Executive Committee. The Medical Executive Committee in its discretion may grant Temporary Privileges to practitioners who are not Members of the Medical Staff as Temporary Members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, or performing an independent review. If a Service concludes that an investigation is warranted, it shall conduct an investigation through a Committee of the Service. If the investigation is conducted by or delegated to a Medical Staff Officer, Committee or Service other than the Medical Executive Committee, such Medical Staff Officer, Committee or Service shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as possible. The report may include recommendations for appropriate corrective action. The Medical Staff Member shall be notified in a timely fashion that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article IX, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action it deems warranted by the circumstances, including but not limited to, summary suspension, termination of the investigative process, or other action.

8.2-4 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as possible after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

(a) determining that no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Member's file;

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

(c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Service Chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action; provided that in the event such letters are issued, the affected Member may make a written

response which shall be placed in the Member's file;

(d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff Membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

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

(f) recommending reductions of Membership status or limitation of any prerogatives directly related to the Member's delivery of patient care;

(g) recommending suspension, revocation or probation of Medical Staff Membership; or

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

8.2-5 SUBSEQUENT ACTION

(a) If corrective action as set forth in Section 9.2(a)-(k) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Chief Executive Officer.

(b) The recommendation of the Medical Executive Committee shall be acted on by the Governing Body in accordance with the standard set forth in Section 6.5-8(c) unless the Member requests a hearing, in which case the final decision shall be determined as set forth in Article IX.

8.2-6 FAILURE TO INVESTIGATE OR TAKE DISCIPLINARY ACTION

If the Medical Executive Committee fails to investigate or take disciplinary action contrary to the weight of evidence, the Governing Body may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Governing Body’s request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to the Governing Body's directive, the Governing Body may take corrective action, provided it has first given written notice to the Medical Executive Committee and provided the Governing Body’s action complies with Section 8.2 and Article IX of these Medical Staff Bylaws.

8.3 SUMMARY RESTRICTION OR SUSPENSION

8.3-1 CRITERIA FOR INITIATION

A Member's appointment to a Medical Staff category may be restricted or suspended summarily whenever a Member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment the life, health or safety of any patient, prospective patient or other person. A Member may also be summarily suspended based on a finding of imminent harm to *prospective patients.* It is not necessary to identify a specific patient. In *Medical Staff of Sharp Memorial Hospital v. Superior Court (Pancoast)* (2004) 121 Ca.App.4th 173, the Court of Appeals reversed the lower court and upheld a summary suspension (even though the physician argued that there was evidence that she did not intend to admit patients until cleared by the medical staff's Physician Well Being Committee). The Chief of Staff, the Medical Executive Committee or the Chief of Service or his/her designee in which the Member holds privileges may summarily restrict or suspend the Medical Staff Membership or clinical privileges of such Member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice by the Governing Body, the Medical Executive Committee and the CEO. In addition, the affected Medical Staff Member shall be provided with a written notice which fully complies with the requirements of Section 8.3-3 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another Member by the Chief of Service or the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute Member.

8.3-2 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as possible after such summary restriction or suspension has been imposed, preferably within five (5) working days, a meeting of the Medical Executive Committee or appropriate Committee thereof shall be convened to review and consider the action. Upon request, the Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose. In no event shall any meeting of the Medical Executive Committee, with or without the practitioner, constitute a "hearing" within the meaning of Article IX nor shall any procedural rules apply. The Medical Executive Committee may modify, continue or terminate the summary restriction or suspension, but in any event it shall furnish the Member with notice of its decision.

8.3-3 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the summary restriction or suspension, the Member (Sec 9.6-3 for Allied Health Professionals) shall be entitled to the procedural rights afforded by Article IX.

8.3-4 INITIATION BY THE GOVERNING BODY

If the Chief of Staff, Members of the Medical Executive Committee or the Chief of the Service (or designee) in which the Member holds privileges are not available to summarily restrict or suspend the Member's Membership or clinical privileges, the Governing Body (or designee) may immediately suspend a member's privileges if a failure to summarily suspend those privileges is likely to result in imminent danger to the health of any individual, provided the Governing Body (or designee) made reasonable attempts to contact the Chief of Staff, Members of the Medical Executive Committee and the Chief of the Service (or designee) before instituting the suspension.

Such suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within five (5) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 8.2 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

8.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's privileges and/or Membership may be suspended or limited as described, which action shall be final without a right to hearing or further review, except where the Medical Executive Committee determines that a bona fide dispute exists as to whether the circumstances have occurred:

8.4-1 LICENSURE

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

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

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

8.4-2 CONTROLLED SUBSTANCES

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

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

8.4-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails without good cause to appear and satisfy the requirements of Section 13.5 shall automatically be suspended from exercising all or such portion of clinical privileges as are specified in accordance with the provisions of that Section.

8.4-4 MEDICAL RECORDS

Medical Staff Members and Allied Health Professionals are required to complete medical records within the time prescribed by the Medical Executive Committee. Failure to timely complete medical records shall result in an automatic suspension following the verbal approval of the Chief of Service, or if unavailable, the Chief of Staff, provided written notice is given as provided in the Rules and Regulations. Such suspension shall apply to the Medical Staff Member’s right to admit, treat, assist in voluntary on-call service for the Emergency Room, or provide services to new patients in the Hospital, but it shall not affect the right to continue to care for a patient the Medical Staff Member has already

admitted or is currently treating. Bona fide vacation or illness may constitute an excuse subject to approval by the Chief of Service. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations and with the approval of the Chief of Service. The suspension shall continue until the medical records are completed.

It is the responsibility of the suspended physician [Member] to designate alternate coverage for his patients.

The Member having incomplete medical records due to circumstances in the Medical Records Department which are beyond his/her controls shall not be subject to the foregoing.

8.4-5 FAILURE TO PAY DUES/ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessment, if any, for each category of Medical Staff Membership, and to determine the manner of expenditure of such funds received, subject to the approval of the Medical Staff. Failure to pay annual dues as required may lead to revocation of Medical Staff Membership.

If within four (4) months after written warnings of delinquency of the Member and does not pay the required dues of assessments, the Member's Membership shall be automatically terminated.

8.4-6 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance within the limits established by the Medical Executive Committee shall be grounds for automatic suspension of a Member's clinical privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. [AHPs]

If within thirty (30) days after written warnings of the delinquency the Member does not provide evidence of required professional liability insurance, the Member's Membership shall be automatically terminated.

ARTICLE IX
HEARINGS AND APPELLATE REVIEWS

9.1 GENERAL PROVISIONS

9.1-1 INTRA-ORGANIZATIONAL REMEDIES

The hearing and appeal rights established in the Bylaws are strictly “judicial” rather than “legislative” in structure and function. The hearing committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of the Bylaws, Rules or policies. However, the Governing Body may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules or policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule or policy is lawful or meritorious, the Member is not entitled to a hearing or appellate review. In such cases, Member must submit his/her challenges first to the Governing Body and only thereafter may he / she seek judicial intervention.

9.1-2 EXHAUSTION OF REMEDIES

If adverse action described in Section 9.2 is taken or recommended, the applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

9.1-3 APPLICATION OF ARTICLE

For purposes of this Article, the term "Member" may include "applicant," as it may be applicable under the circumstances, unless otherwise stated.

9.1-4 TIMELY COMPLETION OF PROCESS

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

9.1-5 FINAL ACTION

Recommended adverse actions described in Section 9.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived and only upon being adopted as final actions by the Governing Body.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall, when taken for a medical disciplinary cause or reason, be deemed an actual or potential adverse action and constitute grounds for a hearing. "Medical disciplinary cause or reason" means that aspect of a Member competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care:

(a) denial of Medical Staff Membership or of any of the privileges of Medical Staff Membership;

(b) denial of requested advancement in Medical Staff Membership status, or category;

(c) denial of Medical Staff reappointment;

(d) demotion to lower Medical Staff category or Membership status;

(e) suspension of Medical Staff Membership;

(f) revocation of Medical Staff Membership or of any of the privileges of Medical Staff Membership;

(g) denial of requested clinical privileges;

(h) involuntary reduction of current clinical privileges;

(i) suspension of clinical privileges;

(j) termination of all clinical privileges; or

(k) involuntary imposition of significant consultation requirements.

9.3 REQUESTS FOR HEARING

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which an action has been taken or a recommendation made as set forth in Section 9.2, the person or body taking the action or making the recommendation shall give the Member prompt written notice of the recommendation or final proposed action and notice that such action, if adopted, shall be taken and reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code.

Such notice shall notify the Member of the right to request a hearing within thirty (30) days pursuant to Section 9.3-2; shall summarize the rights of the Member at the hearing as enumerated under this Article IX; and shall provide notice to the Member of the charges in accordance with Section 9.3-4.

9.3-2 REQUEST FOR HEARING

The Member shall have thirty (30) days following receipt of notice of such action or recommendation to request a hearing. The request shall be in writing addressed to the Medical Executive Committee, care of the

Medical Staff Office, with a copy to the Governing Body, by registered or certified mail or delivered in person. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action in question, which shall thereupon become final and binding.

9.3-3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Staff Office under the direction of the Medical Executive Committee shall schedule a hearing. In no less than thirty (30) days prior to the hearing the Member shall give notice of the time, place and date of the hearing. The date of the commencement of the hearing shall be within sixty (60) days after the date of receipt of the request by the Medical Executive Committee for a hearing the peer review process shall be completed within a reasonable time unless the Hearing Officer issues a written decision finding that the Member failed to comply with his/her responsibilities to provide information to the Medical Executive Committee pursuant to Section 9.4-1, or that the Member consented to the delay.

9.3-4 NOTICE OF CHARGES

Together with the notice of action required by Section 9.3-1, the Medical Executive Committee shall state clearly and concisely in writing the reasons for the recommendation or the final proposed action, including the acts or omissions with which the Member is charged, and shall list the chart numbers of any medical records related to the charges against the Member. The notice of charges may be amended at any time prior to the conclusion of the presentation or oral testimony. If an amendment is made, the Member shall be provided a continuance in order to prepare a response.

9.3-5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive Committee shall determine whether the trier of fact shall be an arbitrator or arbitrators, or a panel of individuals. If the trier of fact is to be an arbitrator or arbitrators, such shall be selected by a process mutually acceptable to the Member and the Medical Executive Committee. If the trier of fact is to be a Judicial Review Committee (JRC), such JRC shall be composed of not less than three (3) members of the Active Medical Staff who shall gain no direct financial benefit from the outcome, and who have not acted as accuser, investigator, witness, fact finder or initial decision-maker in the same matter. The Medical Executive Committee shall appoint the Judicial Review Committee. The JRC shall include one Member who shall have the same healing arts license as the accused and, where feasible, include

an individual practicing the same specialty as the accused. All other Members shall have M.D. or D.O. degrees. Appointment of a JRC shall include the designation of the Committee's Chairman. Knowledge of the matter involved shall not preclude a Member of the Active Medical Staff from serving as a Member of the JRC.

9.3-6 FAILURE TO APPEAR OR PROCEED

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

9.3-7 CONTINUANCES

Continuances, postponements or extensions of time beyond the times expressly permitted in these Bylaws shall be granted upon agreement of the Parties or by the Hearing Officer, arbitrator or presiding officer only upon a showing of good cause. The peer review process shall be completed within a reasonable time, unless the hearing officer, presiding officer or arbitrator issues a written decision finding that the Member failed to comply with the requirements of Section 8.4-3 and 13.5, or consented to the delay.

9.4 HEARING PROCEDURE

9.4-1 Prehearing Procedure.

(a) It shall be the duty of the Member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the Chairman of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

(b) At the written request of either Party to the hearing, the Parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. If the identity of a witness is not disclosed or copies of all documents expected to be produced at the hearing are not produced at least ten (10) days before the commencement of the hearing, the Party entitled to receive such disclosure or production shall have good cause for a continuance.

(c) The Member shall have the right to inspect and copy at the Member's expense any documentary information relevant to the

charges which the Medical Executive Committee has in its possession or under its control, as soon as possible after the receipt of the Member's request for a hearing. The Medical Executive Committee shall have the right to inspect and copy at its own expense any documentary information relevant to the charges which the Member has in his/her possession or control, as soon as possible after receipt of the Medical Executive Committee's request. The failure of either Party to provide access to the information specified in this subparagraph (c) at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either Party does not extend to confidential information referring solely to individually identifiable physicians, other than the Member in review.

(d) The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards that protection of the peer review process and justice require. When ruling upon requests for access to information and determining the relevancy of such requests, the hearing officer shall, among other factors, consider the following:

(1) Whether the information sought may be introduced to support or defend the charges.

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

(3) The burden imposed on the Party in possession of the information sought, if access is granted.

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

(e) The Member shall be entitled to a reasonable opportunity to question and challenge the impartiality of the Judicial Review Committee members and the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee member or the hearing officer shall be ruled on by the hearing officer.

9.4-2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency or character.

The Member may be represented in any phase of the hearing by an attorney licensed to practice law in California, except as provided herein,

or by any other non-attorney representative of the member's choice. In order to exercise the right to be represented at the hearing by an attorney, the Member must give notice in writing of his/her intent to be so represented at least fifteen (15) days prior to the hearing date and in the manner provided for in Section 9.3-2 for requesting a hearing. Failure to give such notice shall constitute a waiver of the right to be represented at the hearing by an attorney at law. The Medical Executive Committee may be represented in any phase of the proceeding by an attorney at law and may appoint a representative to present its action(s) or recommendation (s), the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney at law at the hearing if the Member is not so represented.

9.4-3 THE HEARING OFFICER

The Medical Executive Committee shall appoint a Hearing Officer to preside if a Judicial Review Committee is appointed. The Hearing Officer shall be an attorney at law licensed in California who is qualified to preside over a quasi-judicial hearing. Attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff Member or Applicant for Membership shall not be eligible to serve as hearing officer. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all parties in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as deemed warranted by the circumstances. If requested by the Judicial Review Committee, the Hearing Officer may participate in the deliberations of such committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

9.4-4 RECORD OF THE HEARING

A court reporter shall be present to make a record of the hearing proceedings and the prehearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the Party requesting it. The Judicial Review Committee shall require that oral evidence shall be taken only on oath administered by a person lawfully authorized to administer such oath.

9.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, cross-examine or impeach witness who shall have testified orally on any matter relevant to the issues and otherwise rebut evidence, and submit a written statement at the close of the hearing as long as these rights are exercised in an efficient and expeditious manner. The Member may be called by the Medical Executive Committee and examined as if under cross-examination.

9.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request both sides to file written arguments.

9.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing, the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The Member shall be obligated to present evidence in response. Except as provided for applicants in Section 9.4-7(b), throughout the hearing the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

(b) An Applicant for Membership or new clinical privileges shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for Membership and Privileges. An Applicant shall not be permitted to introduce information requested by the Medical Staff or its representatives which was not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

9.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the Chairman of the Judicial Review Committee, the Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the Member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the timely receipt of closing written arguments, as determined by the Hearing Officer, if requested, the hearing shall be closed.

9.4-9 BASIS FOR DECISION

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences drawn from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these Bylaws.

9.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision in writing which shall be delivered to the Medical Executive Committee. If the Member is currently under suspension, however, the time for the decision and report shall be twenty (20) days. A copy of the decision also shall be forwarded to the Chief Executive Officer, the Governing Body and the Member. The decision shall contain a concise statement of the reasons in support of the decision including findings of fact and conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the Member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these Bylaws. The Governing Body shall take final action on the decision of the Judicial Review Committee in accordance with the requirements of Section 6.5-8(c).

9.5 APPEAL

9.5-1 TIME FOR APPEAL

Within thirty (30) days after receipt of the decision of the Judicial Review Committee, either the Member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Chief Executive Officer, and the other

Party in the hearing. If a request for appellate review is not requested within such period, the Governing Body shall take final action on the decision of the Judicial Review Committee in accordance with the requirements of Section 6.5-8(c).

9.5-2 GROUNDS FOR APPEAL

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

(a) substantial non-compliance with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision which has created demonstrable prejudice;

(b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 9.5-5; or

(c) lack of substantive rationality of a Medical Staff or Service Bylaw or Rule or Regulation relied upon by the Judicial Review Committee in reaching its decision.

(d) action taken arbitrarily, unreasonably, or capriciously.

9.5-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the Appeal Board shall, within sixty (60) days after receipt of a notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than twenty (20) nor more than sixty (60) days from the date of such notice; provided, however, that when a request for appellate review concerns a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed forty-five (45) days from the date of the notice. The time for appellate review and postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any unaffected person and shall be permitted by the Appeal Board for good cause.

9.5-4 APPEAL BOARD

The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board Committee which shall be composed of not less than five

(5) members of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board or Appeal Board Committee, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

9.5-5 APPEAL PROCEDURE

The proceeding by the Appeal Board shall be in the nature of an Appellate Hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Hearing; or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for a decision. Each Party shall have the right to be represented by legal counsel licensed in California, or any other non-attorney representative designated by that Party, in connection with the appeal, to present a written statement in support of his/her position on appeal and to personally or through his representative appear and make oral argument. The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board shall present to the Governing Body its written recommendations as to whether the Governing Body should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

9.5-6 DECISION

(a) Except as provided in Section 9.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings the Governing Body shall render a final decision in accordance with the requirements of Section 6.5-9(a).

(b) Should the Governing Body decide not to affirm the Judicial Review Committee decision, acting in accordance with the requirements of Section 6.5-8(c), the Governing Body may modify or reverse the decision of the Judicial Review Committee and may instead, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the JRC shall promptly conduct its review and make its recommendations to the Governing Body. This further review and the time required to report

back shall not exceed thirty (30) days in duration except as the Parties may otherwise agree or for good cause as jointly determined by the Chairman of the Governing Body and the Judicial Review Committee.

9.5-7 RIGHT TO ONE HEARING

No Member shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter (s) which shall have been the subject of adverse action or recommendation.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 MEDICAL ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS

(a) The fair hearing rights of this Article do not apply to one whose application for clinical privileges was denied on the basis that the privileges sought are granted only pursuant to a closed staff or exclusive use policy. Such Applicant or Member shall have the right, however, to request that the Governing Body review the denial. The Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Applicant or Member may personally appear before and/or submit a statement in support of his/her position to the Governing Body.

(b) The clinical privileges and Medical Staff Memberships of Members who are directly under contract with the Hospital in a medico-administrative capacity or in closed services shall be subject to termination in accordance with the terms of their contracts. Such Members shall not be entitled to the procedural rights of this Article, except to the extent that the Member's Medical Staff Membership or clinical privileges which would otherwise exist independent of the contract are to be limited or terminated, or except when the limitation or termination is for a medical disciplinary cause or reason as defined by Section 9.2. Whenever all of a contract Member's clinical privileges are terminated or suspended, that Medical Staff Member's Membership shall be deemed also terminated or suspended.

9.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF CLINICAL PRIVILEGES

No hearing is required when a Member's license or legal credential to practice has been revoked or suspended as set forth in Section 8.4-1(a). In other cases described in Section 8.4-1 and 8.4-2, the issues which may

be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Member may continue to practice in the Hospital with those limitations imposed.

9.6-3 ALLIED HEALTH PROFESSIONALS

Nothing contained in these Bylaws shall be interpreted to entitle an AHP to the fair hearing rights set forth in Articles VIII and IX. However, the AHP shall have the right to challenge any action that would constitute grounds for a hearing under Section 9.2, by filing a written grievance with the Chief of the Service to which the AHP has been assigned and in which he or she has practice privileges or the right to render the services in question. Such grievance must be filed within fifteen (15) days of such action. Upon receipt of such a grievance, the Service Chief shall initiate a careful investigation and afford the affected AHP an opportunity for an interview before the Service Committee. Whenever possible, the Service Committee shall include, for the purpose of this interview, an AHP holding the same or similar license or certificate as the affected AHP. Such AHPS' shall be appointed to the Service Committee for this purpose by the Service Chair. The interview shall not constitute the a "hearing," as is established by this Article IX and shall not be conducted according to the procedural rules applicable with respect to hearings in these Bylaws. Before the interview, the AHP shall be informed of the general nature of the circumstances giving rise to the proposed action. At the interview, the AHP may present information relevant thereto. A record of the findings of such interview shall be made. A report of the findings and recommendations shall be made by the Service Chief to the Medical Executive Committee which shall act thereon. The action of the Medical Executive Committee shall be final, subject to the approval of the Governing Body.

9.6-4 NATIONAL PRACTITIONER DATA BANK REPORTING

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the "information" set forth in the final action as adopted by the Governing Body. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

9.6-5 DISPUTING REPORT LANGUAGE

If no hearing was requested, a Member who is the subject of a proposed adverse action report to the Medical Board of California and/or the National Practitioner Data Bank may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not

constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, the Chief of Service, and the Hospital's authorized representative, or their respective designees.

If a hearing was held, the dispute process shall be deemed to have been completed.

9.6-6 EXCEPTIONS TO HEARING RIGHTS

A Medical Staff Service can be formed or eliminated only following a determination by the Medical Staff or appropriateness of Service elimination or formation. The Governing Body decision shall uphold the Medical Staff's determination unless the Governing Body makes specific written findings that the Medical Staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

Service Formation or Elimination

(a) The Medical Staff shall determine the formation or elimination of a Service to be appropriate based upon consideration of its effects on quality of care in the facility and/or community. A determination of the appropriateness of formation or elimination of a Service must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment.

(b) The Medical Staff Member(s) whose privileges may be adversely affected by a Medical Staff's determination of appropriateness of Service formation or elimination may request a hearing before the Judicial Review Committee. Such a hearing will be governed by the provisions of Article IX, except that:

(1) the hearing shall be limited to the following issues:

(i) whether the Medical Staff's determination of appropriateness is supported by the preponderance of the evidence; and/or

(ii) whether the Medical Staff followed its requirement for notice and comment on the issue of appropriateness.

(2) all requests for such a hearing will be consolidated.

(c) Should an affected Medical Staff Member request a hearing under

this subsection, the Medical Staff's recommendation regarding the service elimination or formation will be deferred, pending the outcome of the Judicial Review Committee hearing.

(d) Except as specified in this Section, the termination of privileges pursuant to formation or elimination of a Service determined to be appropriate by the Medical Staff shall not be subject to the procedural rights otherwise set forth in Article VII.

ARTICLE X
OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

10.1-1 IDENTIFICATION OF ELECTED OFFICERS

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect, Immediate Past Chief of Staff and Treasurer.

10.1-2 QUALIFICATIONS OF ELECTED OFFICERS

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

10.1-3 NOMINATIONS AND ELECTIONS

(a) A nominating committee shall be appointed by the Medical Executive Committee and shall consist of at least three (3) Members of the Active Medical Staff. Nominations for Officers shall be made by the nominating committee and approved by the Medical Executive Committee

(b) Voting shall be by secret written ballot and authenticated sealed mail ballots may be submitted and counted.

(c) The results of the election of Officers shall be announced at the annual meeting of the Medical Staff. Only Members of the Active and Associate Medical Staff shall be eligible to vote. A nominee shall be elected upon receiving a majority of the valid votes cast. Ballots shall be distributed to the Medical Staff at least 30 days prior to the annual meeting.

(d) Voting shall be by secret written ballot and authenticated. Sealed and mail ballots may be submitted and counted (write in nominees will also be accepted on the ballot and included in the elections)

If no candidate for the Office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

10.1-4 TERM OF ELECTED OFFICERS

The Chief of Staff-Elect shall automatically succeed the Chief of Staff. The Chief of Staff shall automatically become the Immediate Past Chief of Staff. All Officers shall serve a two-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 on a bi-annual basis. No Officer shall serve more than two (2) consecutive terms.

10.1-5 RECALL OF ELECTED OFFICERS

Any Medical Staff Officer may be removed from Office for valid cause, including but not limited to, gross neglect or misfeasance in Office or serious acts of moral turpitude. Recall of a Medical Staff Officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third of the Members of the Medical Staff eligible to vote for Officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Medical Staff Members eligible to vote for Medical Staff Officers who actually cast votes at that special meeting in person or by mail ballot.

10.1-6 VACANCIES IN ELECTED OFFICE

Vacancies in Office occur upon the death or disability, resignation or removal of the Officer or such Officer's loss of Membership in the Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the Office of Chief of Staff, then the Chief of Staff-Elect shall serve out that remaining term and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the Office of Chief of Staff-Elect. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular Staff Meeting. If there is a vacancy in the office of Chief of Staff-Elect, that Office need not be filled by election, but the Medical Executive Committee shall appoint an interim Officer to fill this Office until the next regular election, at which time the election shall also include the Office of Chief of Staff.

10.2 DUTIES OF OFFICERS

10.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as the Chief Officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

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

(b) calling, presiding at and being responsible for the agenda of all meetings of the General Medical Staff;

(c) serving as Chairman of the Medical Executive Committee and calling, presiding at and being responsible for the agenda of all meetings thereof;

(d) serving as an ex-officio member of all other Staff committees without vote, unless his/her membership in a particular committee is required by these Bylaws;

(e) interacting with the Chief Executive Officer and Governing Body in all matters of mutual concern within the Hospital;

(f) appointing Medical Staff officials for special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and except where otherwise indicated.

(g) representing the views, policies and concerns of the Medical Staff to the Governing Body and to the Chief Executive Officer;

(h) coordinating the activities of Administration, Nursing and other Patient Care Services with those of the Medical Staff;

(i) being accountable to the Governing Body, as representative of the Medical Staff, for the quality and efficiency of services and professional performance within the Hospital and for the effectiveness of performance improvement functions delegated to the Medical Staff;

(j) developing and implementing, with the assistance of the other Officials, methods for credentials review and for delineation of privileges, continuing medical education programs, utilization management, concurrent monitoring of practice and retrospective patient care evaluation;

(k) appointing other Officials and Medical Staff representatives to Medical Staff and Hospital management committees, with the exception of the Medical Executive Committee and the Interdisciplinary Practice Committee;

(l) being a spokesperson for the Medical Staff in external professional and public relations;

(m) performing such other functions as may be assigned to him/her by these Bylaws, the Medical Staff or by the Medical Executive Committee;

(n) serving on liaison committees with the Governing Body and the Chief Executive Officer, as well as outside licensing or accreditation agencies;

(o) in the absence of the Chief of Staff and Chief of Staff-Elect, the most recent past Chief of Staff available shall temporarily assume the responsibilities of the Chief of Staff;

(p) acting in a clinical capacity pursuant to indication of the Chain of Command Policy, the Chief of Staff may provide any and all orders necessary to safely and effectively address a clinical patient care issue;

(q) acting in a directive or resource capacity to the Hospital Staff pursuant to indication of the Chain of Command Policy.

10.2-2 CHIEF OF STAFF-ELECT

The Chief of Staff-Elect shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff-Elect shall be a Member of the Medical Executive Committee of the Medical Staff, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

10.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past Chief of Staff shall be a voting Member of the Medical Executive Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Medical Executive Committee.

10.2-4 TREASURER

The Treasurer shall be a Member of the Medical Executive Committee and the Bylaws Committee. His/her duties shall include, but not be limited to:

(a) receiving and safeguarding all funds of the Medical Staff;

(b) providing the Medical Executive Committee with quarterly financial reports and submit semi-annual reports at the General Staff Meetings; and,

(c) performing such other duties as ordinarily pertain to the Office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

ARTICLE XI
SERVICES AND SUBSECTIONS

11.1 ORGANIZATION OF SERVICES

The Medical Staff shall be divided into Services. Each Service shall be organized as a separate component of the Medical Staff and shall have a Chief of Service selected and entrusted with the authority, duties, and responsibilities specified in Section 11.6. A Service may be further divided, as appropriate, into Service Subsections which shall be directly responsible to the Service within which it functions and which shall have a Subsection Director selected by the Service Chief and entrusted with the authority, duties and responsibilities specified in Section 11.5. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of Services and Subsections. However, in no event shall a Service or Service Subsection be created unless and until such Service or Service Subsection consists of at least five (5) Members currently practicing in this Service or Service Subsection for a period a not less than two (2) years.

11.2 CURRENT SERVICES AND SUBSECTIONS

The current Services are:

(a) Medical Service

- Cardiology
- Critical Care
- Family Practice
- Gastroenterology
- Gerontology
- Hematology/Oncology
- Hospice & Palliative Medicine
- Internal Medicine

- Nephrology
- Neurology
- Pediatrics
- Psychiatry
- Pulmonary Medicine
- Radiology

(b) Surgical Service
- Anesthesiology
- Critical Care
- General Dentistry
- General Surgery
- Obstetrics and Gynecology
- Ophthalmic Surgery
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Physical Therapy
- Plastic Surgery
- Podiatric Surgery
- Thoracic Surgery
- Urology
- Vascular Surgery

(c) Emergency Service
- Emergency Medicine

11.3 ASSIGNMENT TO SERVICES

Each Medical Staff Member shall be assigned Membership in at least one Service, and to a Service Subsection, if any within such Service, but may be granted Membership and/or clinical privileges in the other Services or Service Subsections consistent with privileges granted.

11.4 FUNCTIONS OF SERVICES

The general functions of each Service shall include:

(a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Service. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The Service shall routinely collect information about important aspects of patient care provided in the Service, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient

care reviews shall include all clinical work performed under the jurisdiction of the Service.

(b) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the Service.

(c) Evaluating and making appropriate recommendations to the Medical Executive Committee regarding the qualification of applicants seeking appointment or reappointment and clinical privileges within the Service.

(d) Conducting, participating and making recommendations regarding continuing education programs pertinent to the Service's clinical practices.

(e) Reviewing and evaluating Service adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice.

(f) Coordinating patient care provided by the Service's Members with nursing and ancillary patient care services.

(g) Submitting written reports to the Medical Executive Committee concerning: (1) the Service's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the Department and the Hospital.

(h) Conducting meetings not less than quarterly for the purpose of considering patient care review findings, peer review, and the results of the Service's other review evaluation activities, as well as reports on other Service and Medical Staff functions.

(i) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.

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

(k) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Service.

(l) Appointing such committees as may be necessary or appropriate to conduct Service functions.

(m) Formulating recommendations for Service Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee. Service

Rules shall be consistent with these Bylaws and the General Medical Staff Rules and Regulations.

11.5 FUNCTIONS OF SERVICE SUBSECTIONS

Subject to approval of the Medical Executive Committee, each Service Subsection shall perform the functions assigned to it by the Chief of Service. Such functions may include, without limitation, retrospective and concurrent patient care reviews, evaluation of patient care practices, credentials review and privileges delineation, and continuing education programs. The Service Subsection shall transmit regular reports to the Chief of Service on the conduct of its assigned functions.

11.6 SERVICE CHIEFS, VICE CHIEFS AND MEDICAL COMMITTEE CHAIRS

11.6-1 QUALIFICATIONS

Each Service shall have a Chief and Vice-Chief who shall be Members of the Active Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Service. Service Chiefs and Vice Chiefs must be certified by an appropriate specialty board or must demonstrate comparable competence as outlined on the Medical Staff Privilege Delineation Forms.

11.6-2 SELECTION OF SERVICE CHIEFS, VICE CHIEFS AND MEDICAL STAFF COMMITTEE MEMBERS

The selection of the Chief of Medicine, Chief of Surgery, Chief of Emergency Medicine, Vice Chiefs and Medical Staff Committee Members and Chairs shall be elected by the committee members subject to the approval of the Governing Body.

11.6-3 TERM OF OFFICE

The Service Chiefs, Vice Chiefs, Medical Staff Committee Members and Service Subsection Directors shall serve for a period of two (2) calendar years. The Service Chiefs, Vice Chiefs, Medical Staff Committee Members and Service Subsection Directors shall not be appointed for more than two (2) consecutive terms. Upon completion of two (2) consecutive terms by any Service Chief, Vice Chief, Medical Staff Committee Members or Service Subsection Director, such Service Chief, Vice Chief, Medical Staff Committee Members or Service Subsection Director shall be prohibited from acting as such for a period of one (1) term. Upon completion one (1) complete term, the Service Chief, Vice Chief, Medical Staff Committee Members or Service Subsection Director shall be eligible to participate in that capacity for a subsequent term and/or terms.

11.6-4 REMOVAL OF SERVICE CHIEFS AND VICE CHIEFS

Removal of Service Chiefs and Vice Chiefs may be initiated by the Chief of Staff or a two-thirds majority vote of all Active Members of the Service, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and the Governing Body.

11.6-5 DUTIES OF SERVICE CHIEFS

Each Service Chief shall have the following authority, duties and responsibilities and the Vice Chief, in the absence of the Chief, shall assume all of them and shall otherwise perform such duties as may be assigned:

(a) Act as presiding officer at Service or Committee Meetings;

(b) Report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the Service;

(c) Generally monitor the quality of patient care and professional performance rendered by Members with clinical privileges in the Service through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, monitoring functions delegated to the Service by the Medical Executive Committee and in coordination and integration with organization-wide performance improvement activities;

(d) Develop and implement Departmental programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization management and performance improvement;

(e) Serve as a Member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the Service;

(f) Transmit to the Medical Executive Committee the Service's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services and corrective action with respect to persons with clinical privileges in the Service. Assume responsibility for credentialing review and recommendations of initial appointments, reappointments, advancements and extensions on months when the Service does not meet in order to avoid a delay in these processes (actions taken will be reported at

the next Service Meeting for ratification);

(g) Enforce the Medical Staff Bylaws, Rules and Policies and Regulations within the Service;

(h) Implement within the Service appropriate actions taken by the Medical Executive Committee;

(i) Participate in every phase of administration of the Service, including cooperation with the Nursing Service and the Hospital Administration in matters such as personnel (including assisting in determining the qualifications and competence of Service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders and techniques;

(j) Assist in the preparation of annual reports, including budgetary planning, pertaining to the Service as may be required by the Medical Executive Committee;

(k) Recommend delineated clinical privileges for each Member of the Service;

(l) Perform such other duties commensurate with the Office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee;

(m) Act in a clinical capacity pursuant to indication of the Chain of Command Policy, the Chief of Staff may provide any and all orders necessary to safely and effectively address a clinical patient care issue; and

(n) Acting in a directive or resource capacity to the Hospital Staff pursuant to indication of the Chain of Command Policy.

11.6-6 DUTIES OF SERVICE CHIEFS AND COMMITTEE CHAIRS

The duties of Service Chiefs and Committee Chairs shall include but are not limited to the following:

(a) Provide leadership for Quality Council Committee activities, in collaboration with Hospital personnel, to ensure the process measurement, assessment and improvement of the function is performed in a continuous and timely manner. Physician advisors will be assigned for the following functions and reports will be forwarded to the Quality Council Committee:

(i) Operative, Other Invasive and Non-invasive Procedures. Reviewing patient's outcomes as it relates to the performance of operative and other procedures; identifying any trends that may indicate postoperative complications. Assessment of major discrepancies or patterns of discrepancies between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures. Assessment of adverse events or patterns of adverse events associated with the use of anesthesia. The development of criteria for the request of autopsies and policies to insure that autopsies are performed and the findings reported to the Medical Staff.

(ii) Medication Use. Assisting in the formulation of Hospital-wide policies regarding evaluation, selection, procurement, storage, distribution, use, safe prescribing and ordering and other matters relating to medications in the Hospital. Advising the Medical Staff and Pharmacist on matters pertaining to the choice of available medications and alternative medication administration systems. Make recommendations concerning drugs to be stocked on the nursing units and by other Services when the Pharmacy is closed or Service is not available. Oversee the development and review of a formulary or medication list for use in the Hospital based on need for diseases treated, effectiveness, risks of adverse drug reactions, unnecessary stocking duplications, and potential for error as well as acquisition costs and cost impact. Evaluate clinical data concerning a formulary or preparations requested for use in the Hospital. Review, on a continuous basis of admission, preoperative and postoperative standing orders of physicians. Assess all significant adverse drug reactions.

(iii) Blood and Blood Components. The development of proposed policies and procedures for blood and blood products usage. This includes the evaluation of the appropriateness of usage, including the screening, distribution, handling and administration, monitoring of blood and blood components' effects on patients and the assessment of all confirmed transfusion reactions.

(iv) Performance Improvement/Risk Management. Provide leadership for the duties assigned to the Quality Council Committee under Section 12.10 and serve as Chairperson of that Committee.

(v) Utilization Management. The development and implementation of a written Utilization Management Plan based on patient needs and appropriateness to the Hospital. Review admissions and continuation of patient Hospital stay, discharge planning and data collection and reporting. Conduct utilization review studies in conjunction with performance improvements to evaluate the appropriateness of admission to the Hospital, length of stay, discharge practice, use of medical and Hospital services and all related factors which may contribute to the effective utilization of Hospital and physician services. Provide analysis of how under utilization and over utilization of each of the Hospital's services affects the quality of patient care provided. Study patterns of care and obtain criteria relating to the average lengths of stay by patients with specified disease categories.

(vi) Medical Records The review and evaluation of medical records to determine that they adequately describe the condition and progress of the patient, the therapy provided, the result thereof, and the identification of responsibility for all actions taken. Provide direction to ensure that medical records are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Hospital, and that they are adequate in form and content to permit patient care evaluation and other performance improvement activities. Review Medical Staff and Hospital Policies, Rules and Regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage and availability and recommend methods of enforcement and changes. Act upon recommendations from Medical Staff Services or Committees responsible for patient care evaluation and other performance improvement review, evaluation and monitoring functions.

ARTICLE XII
COMMITTEES

12.1 DESIGNATION

Medical Staff Committees shall include but not be limited to, the General Medical Staff Meeting, meetings of Services and Service Subsections, meetings of Committees established under this Article and meetings of special or ad hoc committees created by the Medical Executive Committee or by Services. The Committees described in this Article shall be the standing Committees of the Medical Staff. Medical Staff Committees shall be responsible to the Medical Executive Committee.

12.2 COMMITTEE MEMBERS, TERMS, REMOVAL, AND VACANCIES

Unless otherwise specified, a Committee Member shall be appointed for a term of two (2) years commencing on July 1 and shall serve for said term and until the earlier of (a) the completion of two (2) consecutive terms or (b) his or her successor is appointed, unless he or she shall sooner resign or be removed from the Committee. Committee Members are appointed by the Chief of Staff, subject to the approval of the Medical Executive Committee. Upon completion of two (2) consecutive terms by a Committee Member, such Committee Member shall be prohibited from acting as such for a period of one (1) term. Upon completion of one (1) complete term, the Committee Member shall be eligible to participate in that capacity for a subsequent term and/or terms.

Any Committee Member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Committee. The removal of any Committee Member who is automatically assigned to a Committee because he or she is a general Officer or other official shall be governed by the provisions pertaining to removal of such Officer or official.

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

All actions of the Committee(s), unless otherwise specified, must be approved by a majority vote of a quorum (as set forth in Section 13.7-4 below) present.

12.3 MEDICAL EXECUTIVE COMMITTEE

12.3-1 COMPOSITION

The Medical Executive Committee shall be a standing Committee composed of the following voting Members:

(a) the Officers of the Medical Staff;

(b) the Chiefs of each Service;

(c) the Chairman of the Quality Council;

(d) the Chairman of Infection Control, Pharmacy and Therapeutic Committee;

(e) the Chairman of the Utilization Management Committee;

(f) the Chairman of the Credentialing Committee; and

(g) not more than two (2) Members at large, to be appointed by the Chief of Staff.

The Chief Executive Officer, Chief Nursing Officer, and Director of Performance Improvement/Risk Management shall be non-voting Members.

12.3-2 DUTIES

The duties of the Medical Executive Committee shall be to:

(a) Represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

(b) Coordinate the activities and general policies of the Services and Service Subsections.

(c) Receive and act upon Committee reports.

(d) Implement policies of the Medical Staff not otherwise the responsibility of the Service.

(e) Provide liaison between Medical Staff, the Chief Executive Officer, and the Governing Body.

(f) Recommend action to the Chief Executive Officer on matters of a medico-administrative nature.

(g) Make recommendations on Hospital management matters to the Governing Body.

(h) Fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital.

(i) Assist in obtaining and maintaining accreditation.

(j) Provide for the preparation of all meeting programs, either directly or through delegation to a program Committee or other suitable agent.

(k) Review the credentials of all applicants on recommendation from the Services and Credentials Committee and make recommendations to the Governing Body for Medical Staff Membership, assignments to Services and delineation of clinical privileges.

(l) Review periodically all information available regarding the performance and clinical competence of Medical Staff Members and others with clinical privileges; and, as a result of such reviews to make recommendations for reappointment and renewal or

changes in clinical privileges.

(m) Take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all Members of the Medical Staff, including the participation in Medical Staff review and corrective measures and creating the mechanism for fair hearing procedures.

(n) Evaluate Performance Improvement reports, request investigation of performance issues and direct responsible parties to implement action to resolve Performance Improvement issues that were not resolved at lower level committee and Service meetings.

(o) Account to the Governing Body for the overall quality and efficiency of medical care rendered to patients in the Hospital.

(p) Develop and maintain appropriate plans and procedures for the protection and care of Hospital patients and others at the time of internal or external disasters. The Committee shall adopt and periodically review, in cooperation with the Hospital Administration, a written Plan designed to safeguard patients at the time of an internal disaster. The Committee shall develop and periodically review, in cooperation with Hospital Administration, a written Plan for the care, reception and evacuation of mass casualties and shall coordinate with the inpatient and outpatient services of the Hospital so that the Medical Staff adequately supports the Hospital's role in the event of disasters. The Plan is to be rehearsed semi-annually by all personnel involved.

(q) Submit recommendations to the Governing Body for changes in the Medical Staff Bylaws and the Rules, Regulations and other organizational documents pertaining to the Medical Staff. These recommendations may become effective when ratified by the Governing Body.

(r) Develop and plan or participate in continuing educational programs which inform the Medical Staff of significant new developments in medicine and are responsive to findings of Performance Improvement review and the needs of individuals with clinical privileges as it relates to the management of patients.

(s) Supervise the Hospital's medical library and analyze the Hospital's and its staff's current needs regarding such professional library services.

(t) Recommend clinical privileges for specified professional personnel (i.e., Allied Health Professionals).

(u) Report at each General Staff Meeting.

(v) Develop the mechanism by which Medical Staff Membership may be terminated.

(w) Review the quality and appropriateness of services provided by contract physicians.

(x) Develop changes to the Rules and Regulations if needed in order to meet the requirements of the National survey groups (CIHQ, CMS, etc). These changes must be ratified by the Governing Body.

12.3-3 MEETINGS

The Medical Executive Committee shall meet as often as necessary but at least ten (10) times each year, shall maintain a permanent record of its proceedings and activities and shall report thereon to the Governing Body.

12.4 BYLAWS COMMITTEE

12.4-1 COMPOSITION

The Bylaws Committee shall be a standing Committee composed of the Chief of Staff, and at least two members at-large to be appointed by the Chief of Staff.

12.4-2 DUTIES

The Bylaws Committee shall:

(a) Conduct an annual review of the Medical Staff Bylaws and the Rules, Regulations, procedures and forms promulgated in connection therewith.

(b) Submit recommendations to the Medical Executive Committee and to the Governing Body for changes in these documents as necessary to reflect current Medical Staff practices, law and accreditation requirements.

(c) Act upon all Medical Staff Bylaws-related matters as may be referred by the Governing Body, the Medical Executive Committee, the Services, the Service Subsections, the Chief of Staff, the Chief Executive Officer, and Committees of the Medical Staff.

12.4-3 MEETINGS

The Bylaws Committee shall meet on an as needed basis but at least annually, shall maintain a permanent record of its proceedings and activities and shall report thereon to the Medical Executive Committee.

12.5 CREDENTIALS COMMITTEE

12.5-1 COMPOSITION

The Credentials Committee shall consist of not less than 5 Members of the Active Staff selected on a basis that will ensure, insofar as feasible, representation of major clinical specialties and each of the Medical Staff Services.

12.5-2 DUTIES

The Credentials Committee shall:

(a) review and evaluate the qualifications of each applicant applying for initial appointment, reappointment, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate Services;

(b) submit required reports and information on the qualifications of each applicant applying for Membership or particular clinical privileges including recommendations with respect to appointment, Membership category, Service affiliation, clinical privileges, and special conditions;

(c) investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character, ethics or competence of any applicant or Medical Staff Member; and

(d) Submit periodic reports to the Medical Staff Services on its activities and the status of pending applications.

12.5-3 MEETINGS

The Credentials Committee shall meet as often as necessary at the call of its Chair but at least annually. The Committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee

12.6 MEDICAL ETHICS COMMITTEE

12.6-1 COMPOSITION

The Medical Ethics Committee shall be composed of at least two

Members of the Active Staff, at least two members of the nursing staff, local clergy, social service staff, Administration representative, patient and/or community member, and others as indicated. The Chief of Staff and Chief Executive Officer also have a standing invitation to this Committee. Other individuals on-call to this Committee includes a hospice representative, an attorney and a psychologist, as appropriate.

12.6-2 DUTIES

(a) To assist with ethical considerations within the hospital.

(b) To act as a resource in recommending guidelines regarding issues and practices of an ethical nature to appropriate institutional bodies, such as advanced directives, withholding resuscitative services, forgoing or withdrawing life sustaining treatment care at the end of life and elective treatments.

(c) To oversee any educational programs on ethical issues related to clinical practice for Committee Members, Medical Staff, Hospital and nursing personnel.

(d) To encourage Committee Members to share perspectives and views and to be knowledgeable and comfortable about relating ethical principles to specific issues and cases.

(e) To present, encourage and participate in community programs of preventative health care issues such as advanced directives information.

(f) To develop guidelines for consideration of cases having bioethical implications.

(g) To develop and implement procedures for the review of cases having bioethical implications.

(h) To develop and/or review institutional policies regarding care and treatment of cases having bioethical implications.

(i) To retrospectively review cases for the evaluation of bioethical policies.

(j) To consult with concerned parties, to facilitate communication and aide conflict resolution, to conduct research, and to educate the Hospital staff on bioethical matters.

(k) To review research proposed by either the Hospital or an independent third party entity.

12.6-3 MEETINGS

The Medical Ethics Committee shall meet as necessary but at least annually, shall keep a permanent record of all proceedings and activities, and shall report thereon to the Medical Executive Committee.

12.7 INFECTION CONTROL / PHARMACY & THERAPEUTICS COMMITTEE

12.7-1 COMPOSITION

Membership of the Infection Control / Pharmacy & Therapeutics Committee will include representation from the Medical Staff, Administration, Nursing, Surgery, Environmental Services, Pharmacy, Plant Operations, Dietary, and the person responsible for Infection Control Surveillance.

12.7-2 DUTIES

The duties of the Infection Control / Pharmacy & Therapeutics Committee shall be to:

(a) Develop a Hospital-wide Program for the surveillance, prevention and control of infection.

(b) Identify and analyze the incidence and cause of infections to the extent possible, and coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics.

(c) Develop and implement a preventative and corrective program designed to reduce the risks of endemic and epidemic and health care acquired infections in patients and health care workers.

(d) Institute appropriate control measures or studies when there is felt to be danger to patients or personnel in the Hospital and review sensitivities of organisms specific to the facility.

(e) Develop, evaluate and revise preventative surveillance and control standards, policies and procedures and supervise infection control / pharmacy and therapeutics in all phases of the Hospital's activities including: operating rooms, recovery rooms, delivery rooms, special care units, housekeeping, laundry sterilization and disinfection procedures by heat, chemicals or otherwise; isolation procedures; prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as requested by the Medical

Executive Committee or Administration. Develop proposed policies and procedures for and continuously evaluate the appropriateness of blood and blood products usage, including screening, distribution, handling and administration, and monitoring of blood and blood components' effects on patients and reviewing untoward drug reactions.

(f) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(g) Assist in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital, including antibiotic usage.

(h) Advise the Medical Staff and Pharmacy on matters pertaining to the choice of available drugs. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other Services. Periodically develop and review a formulary or drug list for use in the Hospital.

(i) Act upon the recommendations related to infection control or drug usage received from the Chief of Staff, the Medical Executive Committee, the Services or Service Subsections and other Medical Staff and Hospital Committees. Maintain a record of all activities relating to infection control and pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities.

(j) Evaluate any Medication Plan and efforts to reduce and eliminate medication errors.

12.7-3 MEETINGS

The Infection Control / Pharmacy & Therapeutics Committee shall meet not less than quarterly, shall maintain a permanent record of its proceedings and activities and shall report thereon to the Medical Executive Committee.

12.8 PHYSICIAN WELL BEING COMMITTEE

1) The purpose of the Well Being Committee is to support the well-being of physicians, in so doing to assist affected/disruptive physicians, protect patient welfare, improve patient care, and improve Medical Staff functioning.

2) The Committee works to achieve this purpose through facilitation of, evaluations, referral for treatment of chemical dependence/abuse and behavioral problems of members of the Medical Staff. The Committee is advisory in nature and not a disciplinary body.

3) The Committee is used to foster a culture of mutual concern, safety, professionalism, and confidentiality.

4) The Well Being Committee provides an informal confidential access point for persons who voluntarily seek the counsel and assistance.

5) It also provides a source of expertise whereby the medical staff may identify factors underlying a clinical performance problem for which corrective action is under consideration.

6) In the context of formal investigation regarding clinical performance being conducted by the Medical Executive Committee or similar entity within the organization, the Well Being Committee may be called upon to determine the presence, and the nature, of an underlying problem and make recommendations related to such problems.

7) Referral to this Committee may also be made by others for whom the committee would respect informant confidentiality.

12.8-1 COMPOSITION

Medical Executive Committee shall establish a Physician Well Being Committee comprised of no less than three (3) members, a majority of which, including the Chair, shall be Physician Members of the Active Medical Staff. Each Member shall serve a term of two (2) years, and shall be staggered as deemed appropriate by the Medical Executive Committee in order to achieve continuity. Insofar as possible, Members of this Committee shall not serve as active participants on other peer review activities/committees. If possible, Members of this Committee should have expertise in addiction medicine, psychiatry and/or be personally involved in 12 step programs and recovering from alcoholism or other chemical dependence.

12.8-2 DUTIES

The duties of the Physician Well Being Committee shall be to:

A) Receive reports related to any disruptive behavior, the health, well-being or impairment of Medical Staff Members and, as it deems appropriate, to investigate such reports. For matters involving individual Medical Staff Members, the Committee may provide such

referrals as may seem appropriate. Any initial incident reports shall go to the Chair of the Physician Well Being Committee. These activities shall be confidential except as limited by law, ethical obligation, or when the safety of the patient is threatened. California Title 22 regulations require provision for the assistance of medical care members impaired by chemical dependency and/or mental illness to obtain referral to necessary rehabilitation services. Proceedings shall be considered a peer review committee for purposes of claiming the confidentiality protections afforded by Evidence Code 1157.

B) Referral of the licensed independent practitioner to the appropriate professional internal or external resources for evaluation, diagnosis and treatment of the condition of concerns.

C) Monitoring the licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter if required. (Alternatively, this service may be provided by an outside agency).

D) Initiating appropriate actions when the licensed independent practitioner fails to complete the required rehabilitation program.

E) Assist physicians with the reentry issues.

F) Educate its Members and the Members of the Medical Staff about physician health, well-being and impairment; about appropriate responses to different levels and the kind of distress and impairment; about treatment, monitoring, and recovery; about the responsibilities of the Medical Staff in response to concerns about a physicians health; about the importance of early intervention; and about appropriate resources for prevention, treatment, rehabilitation, monitoring and reentry. (These topics are suggestions and not mandated).

12.8-3 MEETINGS

The Physician Well Being Committee shall meet as often as necessary, but at least quarterly, and shall maintain such records of its proceedings as it deems advisable and shall report on its activities to the Medical Executive Committee as frequently as necessary and at least quarterly. (This is consistent with the Department of Public Health Title 22 regulations). Any records regarding individual Members shall be kept strictly confidential and maintained independently from the general records of the Committee.

12.9 INTERDISCIPLINARY PRACTICE COMMITTEE

12.9-1 COMPOSITION/ORGANIZATION

(a) The Interdisciplinary Practice Committee shall be a standing Committee composed of:

i. three (3) representatives of the Medical Staff appointed by the Medical Executive Committee;

ii. three (3) Registered Nurses appointed by the Chief Nursing Officer;

iii. the Chief Nursing Officer;

iv. Physician Assistant and Nurse Practitioner;

v. the Director of Performance Improvement/Risk Management;

vi. the Chair of the Infectious Control Committee; and

vii. one (1) nurse manager.

(b) There shall be at all times an equal number of voting nurses and Medical Staff Members. Additional ex-officio Members may be appointed by the Chair. A quorum shall consist of a majority of Medical Staff Members and a majority of registered nurses eligible to vote. All actions of the Committee must be approved by a majority of voting Medical Staff Members and a majority of the voting registered nurse members. Prior to approval of standardized procedures, consultation shall be obtained from the facility staff in the medical and nursing specialties under review. Such consultants are given a voice at the Committee meeting but no vote.

12.9-2 DUTIES

The duties involved in establishing policies and procedures for Interdisciplinary Practices are to:

(a) acting as the Credentials Committee for the Allied Health Professional Staff, reviewing and evaluating applications for appointment and reappointment, requests for privileges, and transmitting the Committee's recommendations to the Medical Executive Committee for consideration.

(b) develop and recommended policies and protocols pursuant to the appropriate scope of practice, including the granting of expanded

role privileges to registered nurses to provide for the assessment, planning and direction of the diagnostic and therapeutic care of patients.

(c) review and make recommendations to the Governing Body regarding any patient care policies to be implemented by responsible professionals of the hospital.

(d) periodically review approved Interdisciplinary Practice programs, protocols and policies and their effect on the quality of care.

(e) identify functions and/or procedures which require the formation and adoption of Standardized Procedures under Section 2725 et SCQ of the Business and Professions Code in order for them to be performed by registered nurses and initiate the preparation of such Standardized Procedures.

(f) recommend policies and procedures for the authorization of employed staff registered nurses to perform identified functions and/or procedures. Policies and procedures may be administered by the Committee or delegated to the Director of Patient Care Services.

(g) review and recommend for approval Standardized Procedures covering practice by registered nurses.

12.9-3 MEETINGS

The Interdisciplinary Practice Committee shall meet as needed, but at least annually, shall maintain a permanent record of its proceedings and activities and shall report thereon to the Medical Executive Committee.

12.10 MEDICAL STAFF QUALITY COUNCIL COMMITTEE

12.10-1 COMPOSITION

The Quality Council shall be a committee of the Medical Staff comprised of the Chief of Staff, Chief of Staff-Elect, Medical Services Representative, Surgical Services Representative, OB/GYN Services Representative, Emergency Medicine Representative, one Medical Staff Member at Large, Governing Board Member, Chief Executive Office, CNO, Director of Performance Improvement, Director of Risk Management/Infection Control, Director of Pharmacy and Department Directors as invited.

12.10-2 CHAIRMAN

The Chief of Staff Elect shall be the Chair of the Quality Council.

12.10-3 DUTIES

The Quality Council has oversight responsibility for improving organization-wide quality, patient safety, processes and outcomes of clinical care and service and ensuring compliance with clinical accreditation and regulatory standards. The Quality Council provides an interdisciplinary forum for the medical staff leaders to collaborate with the governing board, hospital leaders and patient care providers to work through high-risk, problem-prone patient care issues to improve organizational quality and patient safety. The fundamental responsibilities and duties of the Quality Council include:

(a) monitor organizational progress on the "prioritized" Annual Performance/Process improvement Projects and other strategic quality/patient safety initiatives.

(b) promote a culture of safety, quality and accountability.

(c) participate in the selection of cross-functional, interdisciplinary and self-directed Performance Improvement Teams and Task Forces and monitor the progress of these groups.

(d) review aggregate data/information from patient safety/quality teams, risk management, infection control, utilization review/case management and other executive/leadership data impacting organization performance.

(e) coordinate and monitor patient safety activities designed to reduce or eliminate potential harm to patients during the delivery of health care services.

(f) develop medical staff performance and outcome measures to identify aggregate trends for further investigation and analysis.

(g) assist in the design or redesign of safe and effective processes of care.

(h) monitor patient satisfaction and customer service activities.

(j) monitor continued improvement in compliance with the selected "Core Measures".

12.10-4 MEETINGS

The Quality Council Committee shall meet as often as necessary, but at least quarterly, shall keep a permanent record of all proceedings and activities and shall report thereon to the Medical Executive Committee and Governing Body.

12.11 UTILIZATION MANAGEMENT COMMITTEE

12.11-1 COMPOSITION

The Utilization Management Committee shall be comprised of the Utilization Management Committee Chair, at least two other representatives of the Medical Staff, along with the Chief Financial Officer, the Chief Nursing Officer, the Business Office Manager, the Manager of Medical Records, the Manager of PI/RM, representatives from Nursing, Discharge Planning and Utilization Management, and others as assigned.

12.11-2 DUTIES

The duties of the Utilization Management Committee are to:

(a) provide direction for the Utilization Management process.

(b) establish goals and objectives for Utilization Management.

(c) select the criteria for appropriateness of admissions, continued stay review and resource consumption.

(d) review data which trends and tracks patterns of practice, and make recommendations for corrective action to the Medical Staff and Administration, as appropriate.

(e) review patient care cases which are referred by the Utilization Management nurse and make recommendations regarding corrective action.

(f) track all denials from third party payers, and participate in the appeal of those denials as necessary.

(g) consider communications from third party payers and managed care which are pertinent to the operation of the Utilization Management Program.

(h) conduct an annual appraisal of the Utilization Management Program and revise the UM plan to reflect current goals and objectives and practices.

12.11-3 MEETINGS

The Utilization Management Committee shall meet as often as necessary, but at least quarterly, shall keep a permanent record of all proceedings and activities and shall report thereon to the Quality Council Committee.

12.12 EDUCATION COMMITTEE

12.12-1 COMPOSITION

The Education Committee shall be comprised of at least three (3) Members of the Active Staff. In addition, a representative of the Nursing Administration and a representative of Hospital Administration shall be voting members of the Committee.

12.12-2 PURPOSE

The purpose of the Education Committee is to assure the availability of ongoing in-house education programs that meet the needs of the Medical Staff and that are responsive to the results of all the Quality Management activities performed by the Staff.

12.12-3 OTHER

The Chair shall maintain formal and regular communications with the Chiefs of the Service and the Chair of all Staff Committees concerned with Quality Management.

12.12-4 MEETINGS

The Education Committee shall meet as needed, but at least annually, shall maintain a permanent record of its proceedings and activities and shall report to the Medical Executive Committee.

12.13 JOINT CONFERENCE COMMITTEE

12.13-1 COMPOSITION

The Joint Conference Committee shall be composed of an equal number of members of the Governing Body and of the Medical Executive Committee, but the Medical Staff Members shall at least include the Chief of Staff, the Chief of Staff-Elect, and the Immediate Past Chief of Staff. The Chair of the Committee shall alternate yearly between the Governing Body and the Medical Staff.

12.13-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and a forum for interaction between the Governing Body and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Governing Body.

12.13-3 MEETINGS

The Joint Conference Committee shall meet as needed, but at least annually, shall maintain a permanent record of its proceedings and activities, and shall report thereon to the Medical Executive Committee.

12.14 PEER REVIEW COMMITTEE (PRC)

12.14-1 COMPOSITION

The PRC will be composed of 10 members in good standing of the Medical Staff. They will be the following: the President-elect of the Medical Staff, the three departmental Chairs, and one elected member from each of the departments of Emergency Medicine, Medicine & Surgery, one from Obstetrics & Gynecology, the Chair of Credentials Committee. There will be non-voting advisors available such as directors of risk management and/or performance improvement as staff support (and others deemed needed from time to time by the PRC). The committee chair will be elected by majority vote from the committee members for a term not less than two years. A quorum will be a simple majority.

12.14-2 DUTIES

a) Oversee both the focused and ongoing Peer Review systems directed primarily toward physician education and performance.

b) The PRC serves as a committee which reports to the Medical Executive Committee.

c) The PRC proposes to the MEC general standards of peer review and monitors the departmental peer review process.

d) The PRC receives summaries and recommendations from departmental chairs.

e) Initial screening is performed within the PRC.

f) Each departmental peer review when requested is conducted in a uniform manner as outlined in the department's peer review protocol.

g) Each chair is responsible for recommending the procedures and goals of their protocol.

h) The written protocol will be forwarded to the PRC for final approval and annual review.

i) The final peer review decision is the responsibility of the PRC.

j) The PRC will assist departmental peer review at the request of the departmental chair.

k) Special circumstances may require the PRC to expedite any review to full review without sending the matter to the department.

l) The PRC reports the results of these peer reviews to the MEC with recommendations from the PRC for subsequent actions.

m) Disciplinary action will be imposed only after due process has been accomplished.

12.14-3 MEETINGS

The Peer Review Committee shall meet at least quarterly, shall maintain a permanent record of its proceedings and activities, and report thereon to the Medical Executive Committee.

12.15 SPECIAL COMMITTEES

Special Committees shall be appointed as may be required to properly carry out the duties of the Medical Staff. Such Committees shall carry out their work, the purpose for which they were appointed and shall report to the Medical Executive Committee. They shall have no power of action unless such is specially granted by the motion which created the Committee. Members of the Special Committee will be appointed by the Chief of Staff.

ARTICLE XIII
MEDICAL STAFF MEETINGS

13.1 GENERAL STAFF MEETINGS

General Medical Staff Meetings shall be held at least semi-annually to conduct any business as deemed necessary by the Medical Executive Committee or the Chief of Staff and to comply with these Bylaws. Additionally, these Meetings shall be used to increase communication between all Members, consider Committee reports, and to take action on any items as needed.

The semi-annual General Staff Meeting preceding the end of each Medical Staff year shall be the Annual Staff Meeting at which an election of officers for the ensuing period shall be conducted.

The Medical Executive Committee shall, by standing resolution, designate the time and place for all General Staff Meetings. Notice of the original resolution and any changes thereto shall be given to each Member of the Staff in the same manner as provided in Section 13.2 for a special meeting.

13.2 SPECIAL MEETINGS

13.2-1 REQUEST

The Medical Executive Committee or at least but not less than one-fourth of the Members of the Active Medical Staff may at any time file a written request with the Chief of Staff, that within seven (7) days of the filing of such request, a Special Meeting of the Medical Staff be called. The Medical Executive Committee shall designate the time and place of any such Special Meeting.

13.2-2 NOTICE

Written notice stating the place, date and hour of any Special Meeting of the Medical Staff shall be delivered, either personally or by mail, to each Member of the Active Staff not less than three (3) or more than seven (7) days before the date of such Meeting. If mailed, the notice of the Meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each Staff Member at his/her address as it appears on the records of the Medical Staff Office in the Hospital. Notice may also be sent to Members of other Medical Staff groups who have so requested.

The attendance of a Member of the Medical Staff at a Meeting to call a Special Meeting shall constitute a waiver of notice of such Meeting. No business shall be transacted at any Special Meeting except that stated in

the notice calling the Meeting.

13.2-3 QUORUM

The presence of one-third (1/3) of the total Membership of the Active Staff shall constitute a quorum at any General or Special Meeting.

13.3 AGENDA

13.3-1 GENERAL MEETING

The agenda at any Regular Meeting of the Medical Staff shall include, insofar as feasible:

(a) Call to order;

(b) Approval of minutes of previous meeting;

(c) Reports of the CEO, Services, and Committees;

(d) Old Business;

(e) New Business;

(f) Educational program (optional);

(g) Election of Officers when required by these Bylaws; and

(h) Adjournment.

13.3-2 SPECIAL MEETING

The agenda at Special Meetings shall be:

(a) Reading of the notice calling the Meeting;

(b) Transaction of business for which the Meeting was called; and

(c) Adjournment.

13.4 EXECUTIVE SESSION

Executive Session is a meeting of a Medical Staff Committee which only voting Medical Staff Committee Members and Ex Officio Members may attend, unless others are expressly requested by the Committee to attend. Executive Session

may be called by the presiding Officer at the request of any Medical Staff Committee Member and shall be called by the presiding Officer pursuant to a duly adopted motion. Executive Session may be called to discuss peer review issues, personnel issues or any other sensitive issues requiring confidentiality.

13.5 COMMITTEE AND SERVICE MEETINGS

13.5-1 REGULAR MEETINGS

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

13.5-2 SPECIAL MEETINGS

A Special Meeting of any Committee or Service may be called by, or at the request of, the Chief of the Service or by the Chair of the Committee, or by one-third of the group's Members [Who is the group], but not less than two (2) Members.

13.5-3 NOTICE OF MEETINGS

Written or oral notice stating the place, date 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 or Service not less than three (3) and not more than seven (7) days before the time of such Meeting by the person or persons calling the Meeting. If mailed, the notice of the Meeting shall be deemed delivered when deposited in the United States mail addressed to the Member at his /her address as it appears on the records of the Medical Staff Office of the Hospital with postage thereon prepaid. The attendance of a Member at a Meeting shall constitute a waiver of notice of such Meeting.

13.5-4 QUORUM

A quorum shall be established by the presence of one (1) physician and either (i) one-third (1/3) of the total numbers of a Committee or Service, or (ii) four (4) Members of such Committee or Service.

13.5-5 MANNER OF ACTION

The action of a majority of the Members present at a Meeting at which a quorum is present shall be the action of the Committee or Service. An action may be taken without a Meeting by unanimous consent in writing signed by each Member entitled to vote at such Meeting.

13.5-6 RIGHTS OF EX OFFICIO MEMBERS

Persons serving under these Bylaws as Ex Officio Members of a Committee shall have all rights and privileges of Regular members except they shall not be counted in determining the existence of a quorum and, unless otherwise specified pursuant to these Bylaws, shall not be entitled to vote.

13.5-7 MINUTES

Minutes of each Regular and Special Meeting of a Committee or Service shall be prepared and shall include a record of the attendance of Members and the vote taken on each matter. The minutes shall be signed by the Chair and submitted to the attendees for approval. Each Committee and Service shall maintain a permanent file of the minutes of each Meeting.

13.5-8 SPECIAL ATTENDANCE REQUIREMENTS

A practitioner whose patient's clinical course is scheduled for discussion at a Special Staff Meeting shall be so notified and shall be expected to attend such Meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the practitioner shall be given by certified mail, return receipt requested, and shall include a statement that his/her attendance at the Meeting at which the alleged deviation is to be discussed is mandatory.

Failure by a practitioner to attend any such Meeting for which he or she was given notice that attendance was mandatory, unless excused by the Medical Executive Committee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical 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 appropriate. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, the presentation may be postponed by the Chief of Staff or by the Medical Executive Committee if the Chief of Staff is the practitioner involved, until not later than the next Regular Staff Meeting. Otherwise the pertinent clinical information shall be presented and discussed as scheduled.

For this section alone, a quorum shall be 2/3 (two thirds) of the voting members of that Committee.

13.6 VOTING

Voting at any Regular or Special Meeting of the Medical Staff may be accomplished by proxy and by mail-in ballot pursuant to policies and procedures set forth and adopted by the Medical Executive Committee.

ARTICLE XIV
CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Hospital, an Applicant:

(a) authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability, ethics and qualifications;

(b) authorizes persons and organizations to provide information concerning such applicant to the Medical Staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this Article; and

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

14.2 CONFIDENTIALITY OF INFORMATION

14.2-1 GENERAL

Records and proceedings of all Medical Staff Committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including but not limited to, General Medical Staff Meetings, meetings of Services, meetings of Committees or Functions established under Article XII, and meetings of Special or ad hoc Committees created by the Medical Executive Committee or by Services and including information regarding any Member or Applicant to this Medical Staff, shall to the fullest extent permitted by law, be confidential.

14.2-2 BREACH OF CONFIDENTIALITY

Effective peer review and consideration of the qualifications of Medical Staff Members and Applicants to perform specific procedures must be based on free and candid discussions. As such any breach of confidentiality of the discussions or deliberations of Medical Staff Services, Service Subsections, Committees or Functions, except in conjunction with other Hospital, professional society or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it

deems appropriate.

14.3 IMMUNITY FROM LIABILITY

14.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and hospital shall be immune, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of his duties as a representative of the Medical Staff or hospital.

14.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and/or Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an Applicant or Member for damages or other relief sought by reason of providing information to a representative of the Medical Staff or of the Hospital or to other third parties concerning such person who is, or has been, an Applicant to or Member of the Staff or who did or does, exercise clinical privileges or provide services at this Hospital.

14.4 ACTIVITIES AND INFORMATION COVERED

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

(a) applications for appointment, reappointment, or clinical privileges;

(b) peer review

(c) corrective action;

(d) hearings and appellate reviews;

(e) utilization reviews;

(f) other Service, Service Subsection, Committee, Function or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and/or

(g) queries and/or reports concerning the National Practitioner Data Bank, peer review organizations, medical societies, medical groups, insurance companies/entities, the Medical Board of California, and all other similar queries and/or reports.

14.5 RELEASES

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

ARTICLE XV
GENERAL PROVISIONS

15.1 RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations 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 Hospital. Such Rules and Regulations shall be a part of but in no case shall supersede these Bylaws, except that they may be amended or repealed by a majority vote of those present at any General Staff Meeting at which a quorum is present and without previous notice or at any Special Meeting on notice by a majority vote of those present of the Active Medical Staff. Following adoption, such Rules and Regulations shall become effective following approval of the Governing Body, which approval shall not be withheld unreasonably or automatically within sixty (60) days if no action is taken by the Governing Body.

15.2 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes.

15.3 AUTHORITY TO ACT

Any Member or Members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

15.4 DIVISION OF FEES

Any division of fees by Members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

15.5 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws,

any and all notices, demands or requests required or permitted to be mailed shall be in writing properly sealed and shall be sent through the United States Postal Service, certified mail, return receipt requested or delivered in person. An alternative delivery mechanism may be used if it is reliable and expeditious and if evidence of its use is obtained. Notice to the Medical Staff, Officers or Committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of Service, Subsection or Committee
C/o Medical Staff Office
San Gorgonio Memorial Hospital
600 North Highland Springs Avenue
Banning, California 92220

Mailed notices to a Member, applicant or other party, shall be to the office at the address as it last appears in the official records of the Medical Staff or the Hospital.

15.6 DISCLOSURE OF INTERESTS

All nominees for election or appointment to Medical Staff offices, Service Chief positions or the Medical Executive Committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, financial affiliations or relationships of which they are reasonably aware which could fore-see-ably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

15.7 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state, and national Hospital Medical Staff Sections (HMSS) should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the Medical Executive Committee.

ARTICLE XVI
ADOPTION AND AMENDMENT OF BYLAWS

16.1 PROCEDURE

Either upon the request of the Medical Executive Committee, the Chief of Staff or the Bylaws Committee (after approval by the Medical Executive Committee), or upon timely written petition signed by at least ten percent (10%) of the Members

of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Such action may be taken at the next General Staff Meeting or by mail ballot following a Regular or Special Meeting of the Medical Staff at which the exact wording of the existing Bylaw language, if any and the proposed change is presented to the members.

16.2 ACTION ON BYLAW CHANGE

For the purpose of enacting a Bylaw change, the change shall require an affirmative vote of a majority of the Membership eligible to vote.

16.2-1 EMERGENCY AMENDMENTS TO THE BYLAWS

The Medical Executive Committee is delegated by the organized Medical Staff to adopt urgent amendments to the Bylaws when there is a documented need to do so in order to comply with law or regulation. The governing body may provisionally approve an urgent amendment without prior notification of the medical staff. The Medical Staff will be immediately notified by the Medical Executive Committee of the amendment so that the Medical Staff can provide retrospective review and comment on the provisional amendment. If there is conflict over the provisional amendment, the amendment will be presented for a vote by the medical staff to reject or ratify the provisional amendment. If there is no conflict, then the provisional amendment stands.

16.3 APPROVAL

Bylaw changes adopted by the Medical Staff shall become effective following acceptance by the Governing Body, which acceptance shall not be withheld unreasonably or shall become effective automatically within sixty (60) days if no action is taken by the Governing Body.

16.4 EXCLUSIVITY

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

16.5 FREQUENCY OF REVIEW

The Medical Staff Bylaws shall be reviewed and approved on an annual basis.

16.6 EFFECT OF THE BYLAWS

Upon adoption and approval as provided in Article XVI, in consideration of the mutual promises and agreements contained in these Bylaws, the Hospital and

the Medical Staff, intending to be legally bound, agree that these Bylaws shall constitute part of the contractual relationship existing between the Hospital and the Medical Staff Members, both individually and collectively.

ADOPTED BY THE GENERAL MEDICAL STAFF ON: 07/18/18

ON FILE	ON FILE
Sherif Khalil, M.D., Chief of Staff	Craig Seheult, M.D., Treasurer

ADOPTED BY THE GOVERNING BODY ON: 08/07/2018

ON FILE	ON FILE
Ron Rader, Chairman	Estelle Lewis, Secretary

ADOPTED BY THE GOVERNING BODY ON: 03/05/2019

ON FILE	ON FILE
Susan DiBiasi, Chair	Estelle Lewis, Secretary

ADOPTED BY THE GOVERNING BODY WITH NO REVISIONS: 05/05/2020

Susan DiBiasi, Chair	Estelle Lewis, Secretary

Revised:	12/07/93
	01/04/94
	06/07/94
	02/07/95
	08/01/95
	01/07/97
	03/03/98
	05/05/00
Reviewed:	06/05/01
	06/20/02
Revised:	06/03/03
Revised:	07/10/07
	09/01/09
Reviewed & Revised:	07/05/11
Revised:	01/10/12
Revised:	01/08/13
Revised:	07/02/13
Revised:	07/01/14

Revised:	01/07/15
Revised/Approved:	07/07/15
Reviewed & Revised:	06/07/16
Approved:	01/10/17
Revised:	**07/18/18**
Approved:	**08/07/18**
Approved:	**03/05/19**

TAB M

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of May 5, 2020

	Title	**Policy Area**	**Owner**	**Workflow Approval**
1	10% Neutral Buffered Formalin Safety	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
2	Abuse - Identification and Reporting of Elder and Dependent Person (Adult)	Administration	Pat Brown, CNO	Bobbi Duffy for Hospital Board of Directors
3	Admission / Registration Protocol	Registration	Eliza Parsons, Director	Bobbi Duffy for Hospital Board of Directors
4	Adult Total Parenteral Nutrition Solution Protocol	Pharmacy	Jose Lopez, Director	Bobbi Duffy for Hospital Board of Directors
5	Aftercare Instructions for Patients Discharged From the Emergency	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
6	Alcohol and Drug Abuse Patients	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
7	Anesthesia Administration in Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
8	Assault Reporting Process for Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
9	Assessment and Reassessment of the Patient	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
10	Assessment of Skin Integrity Upon Arrival to Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
11	Assessment Responsibility in the Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
12	Authorization of Obstetrical Patients	Registration	Eliza Parsons, Director	Bobbi Duffy for Hospital Board of Directors
13	Authorization of Surgical Patients	Registration	Eliza Parsons, Director	Bobbi Duffy for Hospital Board of Directors
14	Automated Drug Dispensing Cabinet System: AcuDose Rx	Pharmacy	Jose Lopez, Director	Bobbi Duffy for Hospital Board of Directors
15	Available Hospital Services	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of May 5, 2020

	Title	Policy Area	Owner	Workflow Approval
16	Basic Emergency Medical Service	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
17	Cardiac Patient: Care of	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
18	Cases Reportable to Health Authorities	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
19	Cervical Spine Clearance	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
20	Clinical Laboratory Quality Management Program	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
21	Clinical Laboratory Scope of Services	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
22	Compounding Aseptic Isolator: Standard Operational Procedure and Maintenance	Pharmacy	Jose Lopez, Director	Bobbi Duffy for Hospital Board of Directors
23	Consent to Treat Emancipated Minor	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
24	Criteria Based Evaluation of Need for Interim Life Safety Measures Due to an Identified Life Safety Code Deficiency	Environment of Care	Dan Mares, Director	Bobbi Duffy for Hospital Board of Directors
25	Dietary Fire Alert (ABC Extinguisher)	Dietary	Lakeisha Hawthorne, Director	Bobbi Duffy for Hospital Board of Directors
26	Emergency Department Computerized Logbook	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
27	Emergency Department Medical Record	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
28	Emergency Department Medication Administration	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
29	Emergency Department Patients in Police Custody	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
30	Emergency Department Scribes	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of May 5, 2020

	Title	Policy Area	Owner	Workflow Approval
31	Emergency Operations Plan	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
32	EMTALA and COBRA Compliance (Patient Transfer & Emergency Medical Treatment & Active Labor Act)	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
33	Equipment Guidelines for New Equipment	Engineering	Dan Mares, Director	Bobbi Duffy for Hospital Board of Directors
34	Extension Cords	Engineering	Dan Mares, Director	Bobbi Duffy for Hospital Board of Directors
35	Fifty-One Fifty Patients in the Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
36	Fire Prevention	Engineering	Dan Mares, Director	Bobbi Duffy for Hospital Board of Directors
37	Follow-Up Care	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
38	Glucose Testing: Accu-Chek Finger Stick (Neonatal Heel Stick) Using Whole Blood	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
39	Glucose Tolerance Testing	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
40	Gram Stains Performed on the 2nd and 3rd Shifts	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
41	Handling and Transport of Specimens to the Lab	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
42	Holding Admitted Patients in the ED	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
43	Immediate Notification of Critical Values and Read Back	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
44	Informed Consent in the Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
45	Initiating Opioid Use Disorder Medication Assisted Treatment	Social Services	Marvin Mitchell, Director	Bobbi Duffy for Hospital Board of Directors

	Title	Policy Area	Owner	Workflow Approval
46	Intraosseous Infusion System	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
47	Intravenous Vancomycin Adult Dosing and Monitoring Protocol	Pharmacy	Jose Lopez, Director	Bobbi Duffy for Hospital Board of Directors
48	Inventory and Searching of Patient Belongings	Nursing	Gayle Freude, Director	Bobbi Duffy for Hospital Board of Directors
49	L.I.S. Maintenance	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
50	L.I.S. Security	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
51	Lab - Fasting Tests	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
52	Lab - Patient Requirements / Prep Prior to Lab Procedures	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
53	Lab - Policy for Ordering Lab Tests	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
54	Lab Specific Standard Precautions	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
55	Lab - Specimens, Collection and Handling	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
56	Labeling of Lab Specimens	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
57	Laboratory Analyzer Relocation	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
58	Laboratory Communication	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
59	Laboratory Downtime Operation	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
60	Laboratory Records and Materials Retention Times	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
61	Laboratory Services for STAT Blood Collection	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of May 5, 2020

	Title	Policy Area	Owner	Workflow Approval
62	Laboratory Services for TIMED Blood Collection	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
63	Left Without Being Seen Patients in the Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
64	Manuals and Records	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
65	Maternal-Child Health/Obstetrics Disaster Plan	Emergency Preparedness	Joey Hunter, Director	Bobbi Duffy for Hospital Board of Directors
66	Medication Storage Area Monthly Inspection	Pharmacy	Jose Lopez, Director	Bobbi Duffy for Hospital Board of Directors
67	Needleless J-Tip Device for Insertion of Peripheral Intravenous (IV) Catheters	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
68	Newborn Abandonment / Safe Surrender	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
69	Notification of Police	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
70	Obstetrical Patient Triage & Medical Screening Examination in the ED	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
71	Participation in Medical Research	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
72	Patient Grievance & Complaint Policy	Administration	Pat Brown, CNO	Bobbi Duffy for Hospital Board of Directors
73	Patient Rights - Therapeutic Diets	Dietary	Lakeisha Hawthorne, Director	Bobbi Duffy for Hospital Board of Directors
74	Patients Presenting to the Emergency Department with Psyciatric or Mental Health Conditions	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
75	Pediatric Assessment, Reassessment	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
76	Piperacillin-Tazobactam (Zosyn®) Extended Infusion	Pharmacy	Jose Lopez, Director	Bobbi Duffy for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of May 5, 2020

	Title	Policy Area	Owner	Workflow Approval
77	POCT Nitrazine Testing	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
78	POCT Quality Management Program	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
79	POCT Visual Urine Dipstick Test	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
80	Poison Control Centers	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
81	Poisonous Plants	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
82	Proficiency Testing Program	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
83	Pronouncing Patients by a Registered nurse - Standardized Procedure	Nursing	Gayle Freude, Director	Bobbi Duffy for Hospital Board of Directors
84	Proper Patient Identification	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
85	Quality of Laboratory Water	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
86	Quality System Assessment Policy	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
87	Rapid Response Team (RRT) - Standardized Procedure	Nursing	Gayle Freude, Director	Bobbi Duffy for Hospital Board of Directors
88	Recall and Follow-Up Care of Patients	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
89	Recapping of Needles	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
90	Reference Intervals	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
91	Referrals	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
92	Repeat Testing for Critical Values and Delta Checks	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors

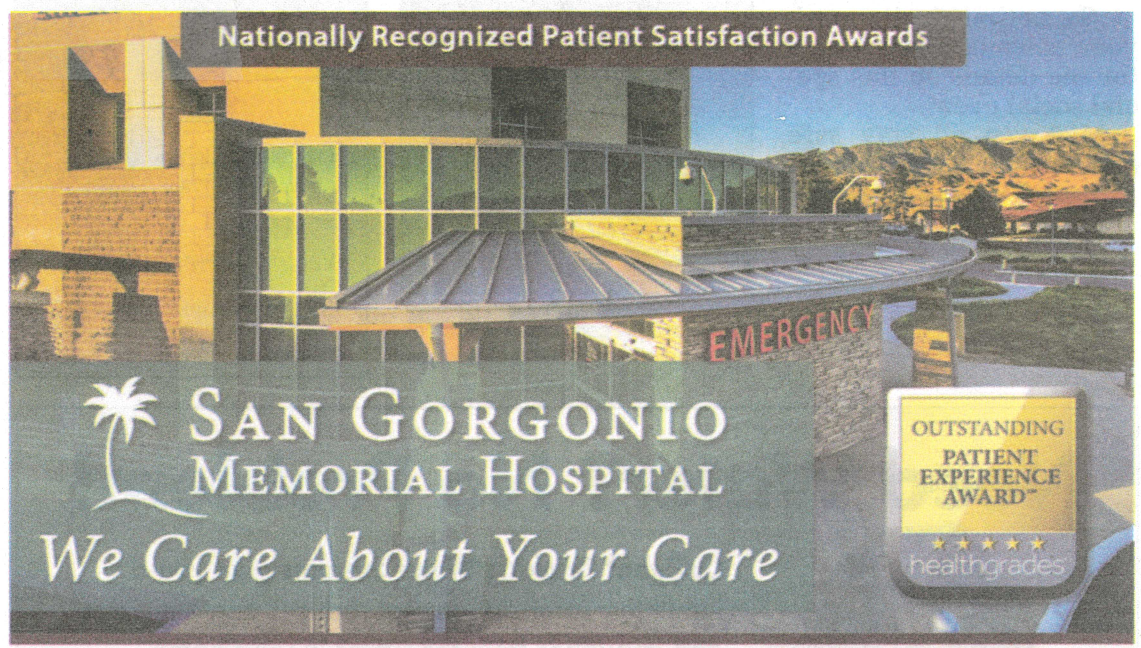
POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of May 5, 2020

	Title	Policy Area	Owner	Workflow Approval
93	Reportable "Unusual Occurrences"	Administration	Pat Brown, CNO	Bobbi Duffy for Hospital Board of Directors
94	Reporting of Results	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
95	Reporting Quality Concerns	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
96	Reports for Infection Control	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
97	Requests to Obtain Forensics Samples by Law Enforcement Agencies	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
98	Required Testing Every 6 Months in Addition to Daily Quality Control	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
99	Restricted Activities in All Technical Work Areas	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
100	Safety Procedures for the Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
101	Security of Laboratory Specimens	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
102	Sexual Assault Intervention	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
103	Snack Vending Machine	Dietary	Lakeisha Hawthorne, Director	Bobbi Duffy for Hospital Board of Directors
104	Specimen Collection and Labelling	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
105	Specimen Identification and Accessioning	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
106	Sterile Compounding: Personnel Cleansing and Garbing	Pharmacy	Jose Lopez, Director	Bobbi Duffy for Hospital Board of Directors
107	Stool Collection	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
108	Storage, Preparation, Evaluation and Tracking of Reagents	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of May 5, 2020

	Title	Policy Area	Owner	Workflow Approval
109	Supervisory Review of Laboratory Results	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
110	Supply Distribution to ED	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
111	Temperature Check of Warmers for Intravenous Fluids and Blankets	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
112	Temperature Logs and Time Control	Dietary	Lakeisha Hawthorne, Director	Bobbi Duffy for Hospital Board of Directors
113	Test Turnaround Times (TAT)	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
114	Therapeutic Automatic Substitution	Pharmacy	Jose Lopez, Director	Bobbi Duffy for Hospital Board of Directors
115	Timely Reporting of Infectious and Communicable Diseases	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
116	Transfer of Severly Ill or Injured Patients to Special Treatment Areas	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
117	Treatment of Patients by Attending Physician	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
118	Triage and Registration of Patients Entering the Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
119	Unaccompanied Minor Patient	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
120	Urine Collection	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
121	Urine HCG Test	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors
122	Vital Signs	Nursing	Gayle Freude, Director	Bobbi Duffy for Hospital Board of Directors
123	Vital Signs Guideline - Emergency Department	Emergency	Angela Brady, Director	Bobbi Duffy for Hospital Board of Directors
124	Whole Blood Glucose Testing Using the Roche® Accuchek Inform II Meter	Clinical Laboratory	Byron Hazley, Director	Bobbi Duffy for Hospital Board of Directors

TAB N



24 HOUR EMERGENCY & RAPID CARE SERVICES

- An expertly trained nursing staff, all certified in advanced cardiac life support & pediatric advanced life support
- State of the art imaging on site, including x-ray, MRI, CT scans, and ultrasounds
- Expert treatment for patients of all ages -- from children to older adults

For More Information: (951) 845-1121
600 North Highland Springs Avenue, Banning CA
Visit Our Website: www.sgmh.org

San Gorgonio Memorial Hospital has been the only hospital in the Pass area for almost 70 years. Our role is now more important than ever as we are on the frontlines with the threat of COVID-19.

In coordination with local, state, and federal agencies, San Gorgonio Memorial Hospital is addressing COVID-19 by identifying cases, isolating patients, and providing outstanding care and the best chance at recovery for all those in need, including some of the most vulnerable in our area. We are also taking extraordinary precautions to protect the community at large and our caregivers and staff. At a time when we must all come together to support prevention, healing, and recovery, SGMH is committed to doing everything in our power to help our communities, especially those in greatest need.

Today, we are asking for your help.

We cannot do this Front-line work alone, so SGMH Foundation has created a "COVID19 Response Fund". Donations to this fund are restricted to SGMH 's response to COVID-19 and treatment of affected patients, including support for:

- Medical supplies
- Equipment, including additional ventilators
- Resiliency training and resources for physicians, nurses, and hospital staff
- Education
- Patient financial assistance
- Funding for additional physicians, nurses, and caregivers

Gifts of any size to our "COVID19 Response Fund" will allow SGMH to address emergent priority needs related to COVID-19.

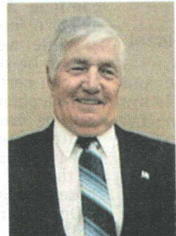
TO DONATE: PLEASE VISIT SGMH.ORG OR SGMHFOUNDATION.ORG or Call the Foundation office at (951) 769-2184 or email vhunter@sgmh.org

San Gorgonio Memorial Hospital is here to help and will continue to be here in the Pass area for you, your family, our neighbors and our community. If you are in a position to support us at this critical time, we would be deeply grateful for your generous contribution.

Sincerely,

Steve Barron - SGMH Chief Executive Officer

George Moyer – SGMH Foundation President



- Emergency Services - **PHONE #: 951-769-2121**
- Orthopedic Services - **PHONE #: 951-846-2877**
- Cardiac Rehabilitation - **PHONE #: 951-769-2134**
- Diagnostic Imaging/MRI - **PHONE # 951-769-2142**
- Obstetrics/Gynecology - **PHONE #: 951-769-2126**
- Physical Therapy - **PHONE #: 951-769-2135**
- Behaviorial Health - **PHONE #: 760-325-2683**
- Nutritional Services - **PHONE #: 951-769-2186**

For More Information: (951)845-1121
600 North Highland Springs, Banning CA 92220
Visit Our Website: www.sgmh.org

San Gorgonio Memorial Hospital seeks contributions in advance of coming surge

BY DAVID JAMES HEISS
Record Gazette

Nearly two-thirds of services at San Gorgonio Memorial Hospital are generally outpatient procedures such as elective surgeries that can be planned in advance.

With many potential customers putting those procedures off, a lot of the non-emergency activity at the local hospital has virtually ground to a halt.

It is revenue the hospital is not generating.

And contributions that normally would have been raised during the hospital foundation's annual spring gala had to be canceled this year due to the pandemic. The gala in 2018 raised just over $200,000, which the San Gorgonio Memorial Hospital Foundation uses to invest in equipment and furnishings for the hospital.

While there has not yet been an apparent rush of coronavirus patients at San Gorgonio Memorial Hospital, the institution is not idly waiting for a moment if it comes.

(The hospital does not share statistics on how many cases, if any, related to COVID-19 that potentially are or have been handled. They refer questions related to such data to the county's public health department).

Dr. Karan Singh, the hospital's emergency room director, notes that the world observed a massive surge of critically sick people that overwhelmed the capacity of Los Angeles and New York hospitals within a short time span.

In part due to the quarantine, and in part because some people are avoiding hospitals out of concern that they could be exposed to infection, a lot of elective procedures have been canceled, he points out.

That means that operating room nurses and other personnel have less to do in their regular departments.

Instead, the hospital has

(See HOSPITAL, page 7)

HOSPITAL

(continued from page 1)

been paying to cross-train them to handle the expected looming coronavirus cases on the horizon, and preparing them to assist in the emergency room and intensive care unit.

At San Gorgonio "We're in pretty good shape. We've had some good planning and we're in daily contact with the county and other agencies" for updates on an anticipated surge of COVID-19 cases, according to San Gorgonio Memorial Hospital Healthcare District board chairman Dennis Tankersley, who anticipates that by April 22, the county will begin to exceed the full hospital bed availability, and by early May as that capacity affects San Gorgonio Memorial Hospital, there will be an increased need for supplies, equipment and trained personnel.

The situation creates a conundrum for hospitals everywhere.

"At a time when you need to spend money to prepare for a surge, there's less money coming in" to pay for those preparations, says CEO Steve Barron. "It's not unique to our hospital, but we can use all the help we can get."

Dr. Singh reports "Our supplies at this time are adequate," from iPads and personnel protective gear to all the equipment necessary for all team members that provide care for each COVID-19

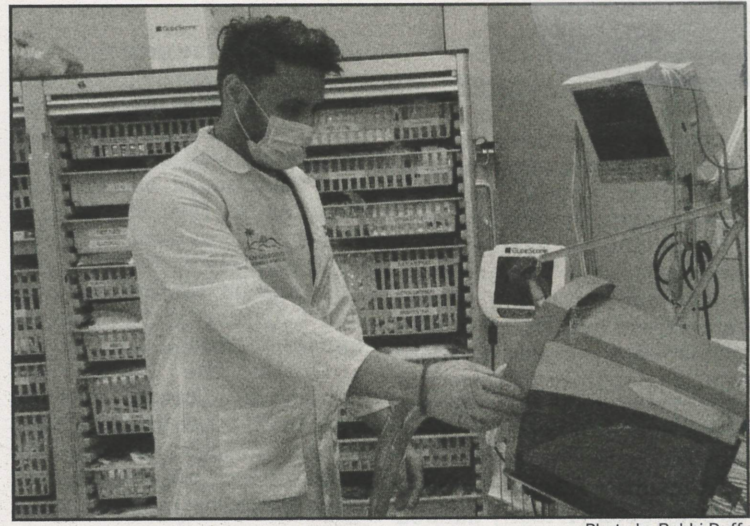


Photo by Bobbi Duffy
Dr. Karan Singh, San Gorgonio Memorial Hospital's emergency department chairman.

patient that comes through, and here has been help from Harbor Freight, which has donated supplies.

That could all change overnight with a pandemic-related surge.

The hospital is hoping that the community can step up and contribute to the nonprofit San Gorgonio Memorial Hospital Foundation, which is overseeing the collection and distribution of donations to fund resiliency training for staff, medical supplies, equipment including additional ventilators, additional staff, as well as patient financial assistance.

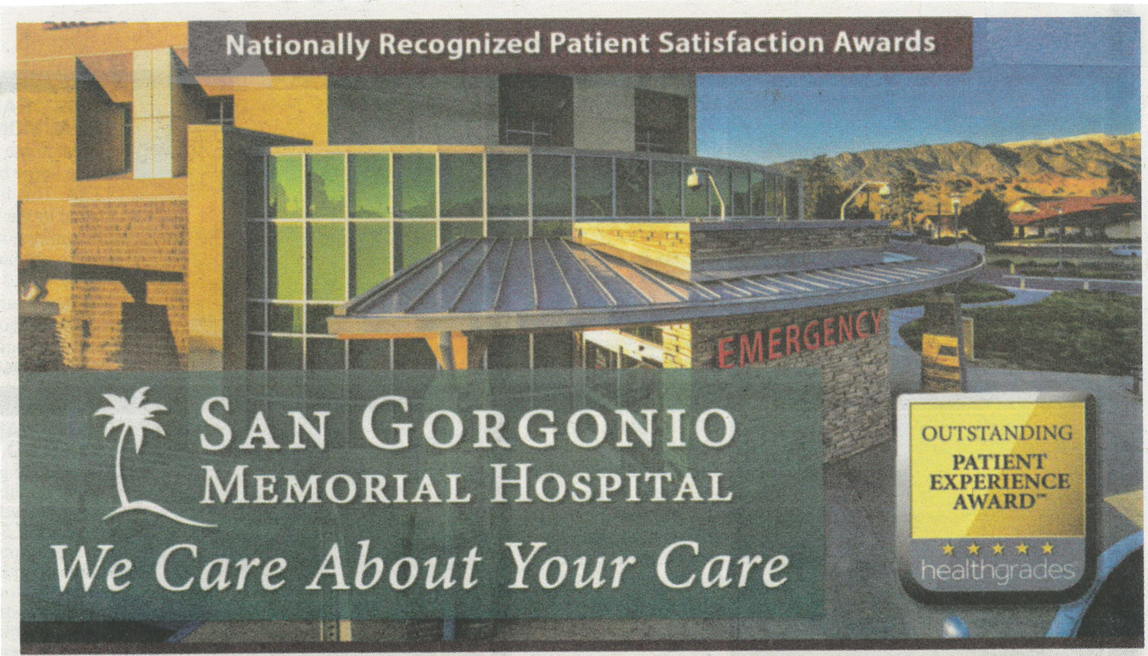
Hospital board Vice Chairman Ehren Ngo reiterates a need for beds and capacity throughout the county.

"These pandemics are lifetime events, but they have the ability to overwhelm the system."

He compliments his hospital's staff for "really having made a commitment to emergency preparedness. They're dedicated to address these issues — and any emergency," Ngo says.

Considering the constant influx of updates and information, and the numbers of virtual meetings and calls within the medical community and public agencies, "We're really thankful for all of our associates and physicians working to take care of the current patient load, while still preparing for the surge," Tankersley adds.

To learn more on how to make contributions to the San Gorgonio Memorial Hospital Foundation's COVID-19 Relief Fund, call (951) 769-2184, or e-mail vhunter@sgmh.org.



24 HOUR EMERGENCY & RAPID CARE SERVICES

- **An expertly trained nursing staff, all certified in advanced cardiac life support & pediatric advanced life support**
- **State of the art imaging on site, including x-ray, MRI, CT scans, and ultrasounds**
- **Expert treatment for patients of all ages -- from children to older adults**

For More Information: (951) 845-1121

600 North Highland Springs Avenue, Banning CA

Visit Our Website: www.sgmh.org

THANK YOU to the Residents of the Pass Area!

San Gorgonio Memorial Hospital is deeply moved by the outpouring of love and compassion of the Pass area community during this time of need. Whether donating medical supplies, BIPAP machines, food, masks, gowns, or giving to our COVID19 Response Fund, our residents, neighbors, friends and community have reminded us that they care about our hospital and we are all in this together.

Our hospital staff cares for you and your loved ones as we would care for our own families. We are here for you!

Resident, Nancy Sheets, Adriana & Anna Nicassio, Lee McIntyre and our own Hospital Volunteer Jewel Parrish are all are making our Hospital associates beautiful homemade masks for our staff to wear proudly.

LifePoint Church in Banning has committed to feeding our evening staff Russo's restaurant every Saturday night and the reviews are wonderful. Before receiving the food, Pastor Tate gave a beautiful prayer in front of the hospital with some hospital staff in attendance. Prayer is very much welcomed.

Starbucks in Banning and Beaumont, donated drinks and snacks to our tired associates during a long shift

Mr. & Mrs. Pedro De Leon and family donated 32 pizzas to feed the entire hospital staff. Such a generous gift.

U.S. Bank – Banning – Eddie Juarez bank manager donated food to feed the Respiratory department and a few other departments. Wow! That really helped a lot of people grab and meal while on the go.

Resident Ben Escelera donated 100 tacos from Los Victors of Banning. Those tacos were a hit! ER, ICU, Respiratory, EVS, Security and Engineering all enjoyed a tasty treat.

Mike the owner of Stop and Shop on 6th street in Beaumont, delivered over 60 burritos for 4 departments to enjoy. This was a wonderful treat.

Jersey Mike's – Cabazon reached out and donated 200 sandwiches to feed the entire hospital staff. Such a beautiful outpouring of support from a brand new business.

Over 250 snack bags and goodies were delivered by Infinite Church-Banning led by Nathaniel Rodriguez along with his sister Ruth Medrano who owns Grand Party Rentals – Beaumont, CA. Our clinical staff was very happy to received snacks that they could grab on-the-go. As dusk started and through a light sprinkle of rain, Nate and Ruth and families also led a prayer over the ER department, which some of the nurses ran out to participate in. The prayers are much needed and appreciated by the entire staff at the hospital. Nate and Ruth and families plan to give snack bags on Sundays as donations allow.

Little Caesars Pizza Beaumont has committed to feeding some of the departments at the hospital. Thank you Little Caesars for helping SGMH.

Forest & Valerie Greek residents of Banning, CA are dedicated to helping the associates at the hospital by providing staff with a delicious meal for our evening shift every Saturday and Sunday. Our staff is very grateful to Mr. & Mrs. Greek for their kindness and generosity.

Matt Smith of Beaumont, gave the hospital some N95 masks he found. What a great help to our frontline staffers.

Harbor Freight Tools in Banning – donated an overwhelming supply of gloves and face shields that help to protect lives.

Exceed A Working Solution – Hemet, CA – donated an awesome amount of surgical masks.

Nadine and Nathan Greenberg of Sun Lakes, Banning donated a BIPAP machine. Wow this is an amazing donation.

Sandra Gustafson donated a CPAP machine. This will be a great help for our clinical staff Hospital associate Bobby Duffy and her neighbor donated 4 CPAP machines. Another valuable machine to help during the hospitals time of need.

Amy Herr of the Boys & Girls club is making homemade hair bend clips for our staff to hook their surgical masks to so that they don't get face burns from the bands attached to the mask by wearing them over 12hrs a day. Amy is also donating activity packets from kids from Kinder to 6th grade for our staff that has kids and needs to keep them occupied while home. Thank you Amy for your love of the hospital staff.

Home Depot of Beaumont donated face shields, shoe covers, full jump suits, cleaning supplies and more to help protect lives – Thank you!

Monetary donations have come in for the COVID 19 Response Fund

Barbara Christensen – Banning, CA
James Close – Banning, CA
Envision Healthcare Charitable fund – Nashville, TN
Joey & Valerie Hunter – San Jacinto, CA
Susan Jameson – Cherry Valley, CA
Annah Karan – Riverside, CA
Bruce & Dianne Patrick – Banning, CA
Christine M. Richardson – Banning, CA
Mike & Kari Spoelstra – Highland, CA
Debra Waddill – Whitewater, CA
Holly & Les Yonemoto, MD – Redlands, CA

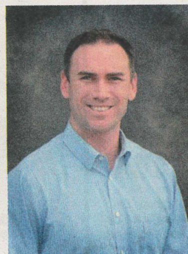
A generous pledge of $10,000 from Steve and Janyce Barron – Lake Arrowhead, CA

As well as a generous pledge from the San Gorgonio Memorial Hospital Foundation of $30,000 for personal protective equipment (PPE) for our staff.

We are so thankful and If you or someone you know would like to make a monetary donation to our COVID19 Response Fund please visit SGMH.org OR SGMHFoundation.org and click on the DONATE button to make a secure and safe donation. If you'd like donate homemade masks, medical equipment, gloves or have a question about donations, please contact the Foundation department at (951) 769-2184 or email Valerie Hunter @ vhunter@sgmh.org

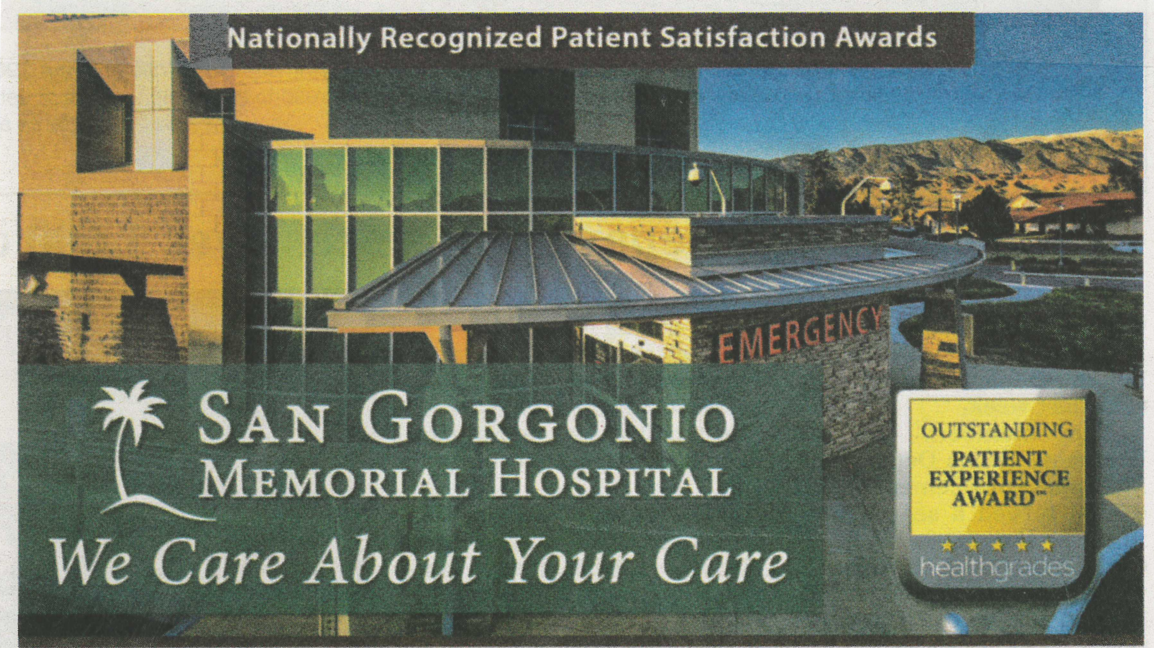
On behalf of the entire staff, physicians and administration of San Gorgonio Memorial Hospital

Thank you for your warm appreciation and generosity during this unprecedented time.


Dennis Tankersley, PA-C
Health Care District Board Chair

Susan DiBiasi
Hospital Board Chair

George Moyer
Foundation Board Chair



24 HOUR EMERGENCY & RAPID CARE SERVICES

- An expertly trained nursing staff, all certified in advanced cardiac life support & pediatric advanced life support
- State of the art imaging on site, including x-ray, MRI, CT scans, and ultrasounds
- Expert treatment for patients of all ages -- from children to older adults

For More Information: (951) 845-1121
600 North Highland Springs Avenue, Banning CA
Visit Our Website: www.sgmh.org

THANK YOU

to All of Our

SAN GORGONIO MEMORIAL HOSPITAL

HEALTHCARE HEROES!!!

These have been trying weeks and we want to thank each individual at SGMH for all they are doing – it takes a team and we have an extraordinary team here at SGMH, caring for the community.

We are here for you and your family for all your healthcare needs - keeping you safe in the midst of your care.

Thank you ALL – nurses, doctors, and staff in every position!!!

Thank you to the community for supporting us as we support you and your family members.

Thank you,

SGMH Administration & Board

SGM Health Care District Board

Dennis Tankersley, PA-C
Health Care District Board Chair

Susan DiBiasi
Hospital Board Chair