Washington Township Health Care District
2000 Mowry Avenue, Fremont, California 94538-1716 | 510.797.1111
Kimberly Hartz, Chief Executive Officer

BOARD OF DIRECTORS MEETING
Wednesday, July 13, 2022 – 6:00 P.M.
Meeting Conducted by Zoom
https://us06web.zoom.us/j/83385132445?pwd=bUxLdzI5Y3lOWWJNckxHc3Zob29FUT09
Password: 084870

AGENDA

		PRESENTED BY:
I.	**CALL TO ORDER & PLEDGE OF ALLEGIANCE**	Jeannie Yee Board President
II.	**ROLL CALL**	Dee Antonio District Clerk
III.	**BROWN ACT FINDING** GOVERNMENT Code § 54953(e)(3)(B)(ii)	*Motion Required*
IV.	**COMMUNICATIONS**	
	A. Oral *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not on the agenda and within the subject matter of jurisdiction of the Board.. "Request to Speak" cards should be filled out in advance and presented to the District Clerk. For the record, please state your name.*	
	B. Written	
V.	**CONSENT CALENDAR** *Items listed under the Consent Calendar include reviewed reports and recommendations and are acted upon by one motion of the Board. Any Board Member or member of the public may remove an item for discussion before a motion is made.*	Jeannie Yee Board President
	A. Consideration of Minutes of the Regular Meetings of the District Board: June 8, 20, 22, and 27, 2022	*Motion Required*
	B. Consideration of Medical Staff: Bylaws	
	C. Consideration of Medical Staff: Organization Manual	

D. Consideration of Medical Staff: Conflict of Interest Disclosure Statements

E. Consideration of Neuroptics Pupillometer NPi-300

F. Consideration of Project Budget for Relocation of Cardiology Offices to Fremont Office Center

G. Consideration of Philips EPIQ Cardiovascular Ultrasound Systems

H. Consideration of Appointment to DEVCO Board: Pauline Weaver

VI.	**PRESENTATION**	**PRESENTED BY:**
	A. Facility Master Plan	Ed Fayen Executive Vice President & Chief Operating Officer
VII.	**REPORTS**	**PRESENTED BY:**
	A. Medical Staff Report	Shakir Hyder, M.D. Chief of Medical Staff
	B. Service League Report	Debbie Feary Service League President
	C. Quality Report: Mobility Program	Alisa Curry PT DPT Coordinator of Rehab Clinical Programs
	D. Finance Report	Chris Henry Vice President & Chief Financial Officer
	E. Hospital Operations Report	Kimberly Hartz Chief Executive Officer

VIII. ANNOUNCEMENTS

IX. ADJOURN TO CLOSED SESSION

A. Conference involving Trade Secrets pursuant to Health & Safety Code section 32106

X. RECONVENE TO OPEN SESSION & Jeannie Yee

	REPORT ON PERMISSIBLE ACTIONS TAKEN DURING CLOSED SESSION	Board President
XI.	**ADJOURNMENT**	Jeannie Yee Board President

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact the District Clerk at (510) 818-6500. Notification two working days prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to this meeting.

CALL TO ORDER

A meeting of the Board of Directors of the Washington Township Health Care District was held on Wednesday, June 8, 2022 via Zoom. Director Yee called the meeting to order at 6:00 pm and led those in attendance of the meeting in the Pledge of Allegiance.

PLEDGE OF ALLEGIANCE

ROLL CALL

Roll call was taken: Directors present: Jeannie Yee; Bernard Stewart, DDS; Michael Wallace; Jacob Eapen, MD; William Nicholson, MD

Also present: Kimberly Hartz, Chief Executive Officer; Cheryl Renaud, Acting District Clerk

Guests: Chris Henry, Tina Nunez, Larry LaBossiere, Paul Kozachenko, Angus Cochran, Dr. Bettina Kurkjian, Dr. Brian Smith; Debbie Feary, Donald Pipkin, Dr. Jack Rose, John Zubiena, Kel Kanady, Kristin Ferguson, Maria Nunes, Mary Bowron, Nick Legge, Dr. Prabhjot Khalsa, Sabrina Valade, Dr. Shakir Hyder, Sri Boddu

OPENING REMARKS

Director Yee welcomed any members of the general public to the meeting. She noted that in order to continue to protect the health and safety of the members of the Board, District staff, and members of the public from the dangers posed by the SARS-CoV-2 virus, the Brown Act allows a local agency to continue to hold its meetings remotely as opposed to being required to meet in-person. Section 54953(e)(3) of the Government Code requires that the Board make certain findings every 30 days to continue meeting remotely. One such finding is that "state or local officials continue to impose or recommend measures to promote social distancing." The Alameda County Health Officer continues to recommend social distancing and the wearing of masks indoors, as referenced by the Alameda County Health Care Services Public Health Department COVID-19 website at www.covid-19.acgov.org.

In accordance with District law, policies, and procedures, Director Wallace moved that the Board of Directors make the finding required by Section 54953(e)(3)(B)(ii) of the Government Code that "state or local officials continue to impose or recommend measures to promote social distancing." Director Stewart seconded the motion.

Roll call was taken:

Jeannie Yee – aye
Bernard Stewart, DDS – aye
Michael Wallace – aye
Jacob Eapen, MD – aye
William Nicholson, MD – aye

The motion carried and the finding is affirmed.

Director Yee noted that Public Notice for this meeting, including connection information, was posted appropriately on our website. This meeting, conducted via Zoom, is being recorded for broadcast at a later date.

COMMUNICATIONS: ORAL

There were no Oral communications.

COMMUNICATIONS: WRITTEN

There were no Written communications.

CONSENT CALENDAR

Director Yee presented the Consent Calendar for consideration:

A. Minutes of the Regular Meetings of the District Board: May 11, May 16, May 23, and May 25, 2022
B. Critical Care Medicine Privileges
C. Recognition of Local 20 as the Bargaining Representative for the Case Managers and Social Workers in Social Services at Washington Hospital

In accordance with District law, policies, and procedures, Director Wallace moved that the Board of Directors approve the Consent Calendar, items A through C. Director Stewart seconded the motion.

Roll call was taken:

Jeannie Yee – aye
Bernard Stewart, DDS – aye
Michael Wallace – aye
Jacob Eapen, MD – aye
William Nicholson, MD – aye

The motion unanimously carried.

PRESENTATION: STROKE PROGRAM

Kimberly Hartz, Chief Executive Officer, introduced Jack Rose, MD, Co-Medical Director for the Stroke Program. Dr. Rose presented the Stroke Program Calendar Year 2021 Review and Quality Report. He touched upon the Stroke Program structure, the leadership, patient outcomes, stroke patient volume, guidance and dissemination of data, performance improvement, and patient satisfaction data. Dr. Rose also discussed the stroke alert process: Code Neuro, the achievements and goals of the program, program goals for 2021-2022, and Neuroradiology and vascular neurosurgery procedure volumes. He also noted that working closely with EMS is vital to a seamless acute stroke system of care and for optimally rapid tPA. Dr. Rose reviewed the education given to staff, patients and the community, as well as the early warning signs of a stroke.

Notable Achievements in 2021:

- Get With the Guidelines Award-Gold Plus Elite Award for Stroke and Target Honor Roll for Diabetes.
- Achieved Primary Stroke Recertification from Joint Commission (TJC).
- Increased number of thrombectomy cases and have added neurointerventional coverage.
- Expanded services to San Joaquin Valley, with increased volume of neurointerventional procedures.
- Developed marketing strategies for Neuroscience Program

MEDICAL STAFF REPORT

Dr. Shakir Hyder, Chief of Staff, reported there are 573 Medical Staff members including 341 active members. He noted that the COVID numbers are rising in California, as well as an increase in the Hospital COVID census.

SERVICE LEAGUE REPORT

Debbie Feary, Service League President, reported that the Service League contributed 1,299 hours over the past month on a wide variety of assignments: serving in the gift shop, assisting nurses in telemetry and the Morris Hyman Critical Care Pavilion. The service league hosted three orientations, during which they were able to recruit five new adult volunteers and 25 college volunteers. They also welcomed back their high school volunteers in a limited capacity. Training began for 11 high school volunteers in the lobby this week, and they are looking at opening up evening shifts at a later date. The Nurse Unit Assist Program also restarted in the Emergency Department.

PRESENTATION: LEAN REPORT-WTMF QUALITY ALIGNMENT

Kimberly Hartz, Chief Executive Officer, introduced Bettina Kurkjian, MD, Kaizen Promotion Office, and Sabrina Valade, Director of Strategic Planning. The presentation topic was WTMF Quality Alignment. WTMF has a large presence in the community providing 180,000 patient visits per year, with 20 clinic sites, 89 physicians and 12 advanced practice providers (PA's, NP's). They also provide a wide range of comprehensive care, including primary care and specialty services. They partner closely with Washington Hospital providing inpatient critical care, surgical, orthopedic and obstetric hospitalist care. Patients utilize the Hospital ancillary services, laboratory, radiology and physical therapy. WTMF continues to run a COVID testing and vaccine program for the community.

Also discussed was the Quality Incentive Pool (QIP), which is a California Department of Health Services pay for performance program available to public hospitals. The goal is to improve care for the Medi-Cal population in four strategic areas: primary care, specialty care, inpatient care, and resource utilization. The annual investment in District Hospitals is $100 million dollars. Investment allows participating hospitals to building infrastructure to enhance quality for all patients. The Hospital QIP program has 20 quality measures to maximize the opportunity. Also discussed were the key lean principles, steps on improving quality standards, infrastructure development in progress, the working group concept and the daily management of visibility boards and goals. It is anticipated to achieve 100% of QIP targets for 2021.

FINANCE REPORT

Chris Henry, Vice President & Chief Financial Officer, presented the Finance Report for April 2022. The average daily inpatient census was 140.5 with admissions of 764 resulting in 4,216 patient days. Outpatient observation equivalent days were 275. The average length of stay was 5.99 days. The case mix index was 1.627. Deliveries were 106. Surgical cases were 373. The Outpatient visits were 7,414. Emergency visits were 4,186. Cath Lab cases were 200. Joint Replacement cases were 179. Neurosurgical cases were 23. Cardiac Surgical cases were 6. Total FTEs were 1,517.2. FTEs per adjusted occupied bed were 6.12.

HOSPITAL OPERATIONS REPORT

Kimberly Hartz, Chief Executive Officer, presented the Hospital Operations Report for May 2022. Preliminary information for the month indicated total gross revenue at approximately $197,299,000 against a budget of $182,719,000. We had 47 COVID-19 discharges which represented 5% of total discharges.

The Average Length of Stay was 5.67. The Average Daily Inpatient Census was 152.1. There were 10 discharges with lengths of stay greater than 30 days, ranging from 31 to 309. Still in house at the end of May were seven patients with length of stays of over 30 days and counting (highest at 370).

There were 4,715 patient days. There were 384 Surgical Cases and 196 Cath Lab cases at the Hospital. Outpatient joint cases were budgeted to begin migrating to Peninsula Surgery Center in October 2021. The Medicare accreditation survey was completed on April 28, 2022. The first four surgeries at PSC were performed on May 31, 2022.

Deliveries were 131. Non-Emergency Outpatient visits were 7,451. Emergency Room visits were 4,755. Total Government Sponsored Preliminary Payor Mix was 73.5%, against the budget of 72.2%. Total FTEs per Adjusted Occupied Bed were 6.16. The Washington Outpatient Surgery Center had 485 cases and the clinics had approximately 16,481 visits.

There were $312,000 in charity care applications pending or approved in May.

ANNOUNCEMENTS

- Friday, May 6th: Athletic Trainers from Washington Sports Medicine volunteered to serve as the medical coverage for a Special Olympics Track event.
- Thursday, May 12th: Dr. Seema Sehgal, Psychiatrist, and Wajeeha Khan, LMFT, gave onsite presentations at Ardenwood Elementary School for National Mental Health Awareness Month.
- Thursday, May 12th: Dr. Bhaskari Peela, Pediatrician, presented, "Kindergarten Readiness" on Facebook Live and YouTube.
- Wednesday, May 18th: Kristi Caracappa, Health Insurance Information Service Coordinator, presented information on Advance Health Care Directives and POLST (Physicians Orders for Life Sustaining Treatment) to the Residence of Acacia Creek Retirement Community in Union City.
- Thursday, May 19th: Washington Hospital hosted "Celebration of Life". This event featured stories of survival and hope for cancer survivors and their families. The event was sponsored by Washington Hospital, HERS Breast Cancer Foundation, UCSF - Washington Cancer Center, Invitae and the Tri-City Voice.
- Friday, May 20th: The Washington Hospital's Green Team promoted Bike to Wherever Day.
- Critical Care Celebration Month was celebrated in May with the theme of "Diversity, Equity and Inclusion". Activities included a Multidisciplinary Grand

Rounds on May 20th with a presentation on "COVID: Past, Present Future" from Dr. Monica Gandhi.

- Saturday, June 4th: Washington Hospital hosted their Tattoo Removal Clinic in partnership with Second Chance, a Newark-based counseling and recovery agency.
- As of Tuesday, May 31st, a total of 89,231 COVID vaccine doses have been administered to community members at our vaccination clinic. This represents all first and second doses, as well as third booster doses. The total number of people who have received a COVID vaccine is 42,790. Additionally, 18,949 boosters have been administered. On November 3rd, we began vaccinating children ages 5 to 11 years old. As of Tuesday, May 31st, a total of 3,593 vaccinations have been administered to this age group.
- Scheduled for Thursday, June 9th: Dr. Tam Nguyen, Family Medicine, will present, "Men: Take Charge of Your Health!"
- Scheduled for Wednesday, June 29th: Maria Nunes, Clinical Manager of the Stroke Program, will present information on Stroke Awareness to the Residence of Acacia Creek Retirement Community in Union City.
- Washington Hospital Healthcare Foundation's 35th Annual Golf Tournament took place on Thursday, May 5th at the Club at Castlewood. After expenses, the Tournament raised over $68,000 for the Surgical Services Fund.
- June Employee of the Month: Venches Vergara, Staffing Clerk, Patient Care Services Division

ADJOURN TO CLOSED SESSION

In accordance with Health & Safety Code Section 32106, Director Yee adjourned the meeting to closed session at 7:35 p.m., as discussion pertained to Trade Secrets. Director Yee stated that the public has a right to know what, if any, reportable action takes place during closed session. Since this is a Zoom session and we have no way of knowing when the closed session will end, the public was informed they could contact the District Clerk for the Board's report beginning June 9, 2022. She indicated that the minutes of this meeting will reflect any reportable actions.

Director Yee reconvened the meeting to open session at 7:58 p.m. There was no reportable action taken in closed session.

ADJOURNMENT

There being no further business, Director Yee adjourned the meeting at 7:59 p.m.

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Jeannie Yee
President

William Nicholson, M.D.
Secretary

CALL TO ORDER

A regular meeting of the Board of Directors of the Washington Township Health Care District was held on Monday, June 20, 2022 via Teleconference. Director Yee called the meeting to order at 6:01 p.m. and led those present in the Pledge of Allegiance.

ROLL CALL

Roll call was taken. Directors present: Jeannie Yee; Bernard Stewart, DDS; Michael Wallace; William Nicholson, MD
Absent: Jacob Eapen, MD

Also present: Kimberly Hartz, Chief Executive Officer; Ed Fayen, Chief Operating Officer, Chris Henry, Chief Financial Officer; Larry LaBossiere, Chief Nursing Officer; Paul Kozachenko, Legal Counsel; Dee Antonio, District Clerk

Guests: Mike Matson, Doug Strout

OPENING REMARKS

Director Yee welcomed any members of the general public to the meeting. She noted that in order to continue to protect the health and safety of the members of the Board, District staff, and members of the public from the dangers posed by the SARS-CoV-2 virus, the Brown Act allows a local agency to continue to hold its meetings remotely as opposed to being required to meet in-person. Section 54953(e)(3) of the Government Code requires that the Board make certain findings every 30 days to continue meeting remotely. One such finding is that "state or local officials continue to impose or recommend measures to promote social distancing." The Alameda County Health Officer continues to recommend social distancing and the wearing of masks indoors, as referenced by the Alameda County Health Care Services Public Health Department COVID-19 website at www.covid-19.acgov.org. The Board made such a finding at its meeting earlier in the month.

COMMUNICATIONS

There were no oral or written communications.

CONSENT CALENDAR

Director Yee presented the Consent Calendar for consideration:

A. Isolation Stations
B. Stanley Real Time Location System
C. Philips EPIQ Cardiovascular Ultrasound
D. Philips Intrasight 5 Mobile Intravascular Ultrasound (IVUS)
E. Trackcore Same Day
F. Two Philips ST80i Stress Test Systems

In accordance with District law, policies, and procedures, Director Wallace moved that the Board of Directors approve the Consent Calendar, items A through F. Director Nicholson seconded the motion.

Roll call was taken:

Jeannie Yee – aye
Bernard Stewart, DDS – aye
Michael Wallace – aye
Jacob Eapen, MD – absent
William Nicholson, MD – aye

The motion carried.

ANNOUNCEMENTS

Kimberly Hartz announced that Washington Hospital was named as the next designated Level 2 Trauma Center for Alameda County. The official announcement was made June 14th by Alameda County Emergency Medical Services Agency.

ADJOURN TO CLOSED SESSION

In accordance with Health & Safety Code Sections 32106, 32155 and California Government Code 54956.9(d)(2), Director Yee adjourned the meeting to closed session at 6:08 p.m., as the discussion pertained to a Conference involving Trade Secrets pursuant to Health & Safety Code 32106, Conference with Legal Counsel regarding Anticipated Litigation pursuant to Government Code section 54956.9(d)(2), and consideration of closed session Minutes: May 16, and 25, 2022. Director Yee stated that the public has a right to know what, if any, reportable action takes place during closed session. Since this meeting is being conducted via Zoom and we have no way of knowing when the closed session will end, the public was informed they could contact the District Clerk for the Board's report beginning June 21, 2022. She indicated that the minutes of this meeting will reflect any reportable actions.

RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION

Director Yee reconvened the meeting to open session at 8:35 pm. The District Clerk reported that the Board approved the Closed Session Minutes of May 16, and 25, 2022 by unanimous vote of all Directors present:

Jeannie Yee
Bernard Stewart, DDS
Michael Wallace
William Nicholson, MD

ADJOURNMENT

There being no further business, Director Yee adjourned the meeting at 8:35 pm.

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Jeannie Yee
President

William Nicholson, M.D.
Secretary

CALL TO ORDER

A regular meeting of the Board of Directors of the Washington Township Health Care District was held on Wednesday, June 22, 2022 via Zoom. Director Yee called the meeting to order at 6:04 p.m. and led those present in the Pledge of Allegiance.

ROLL CALL

Roll call was taken. Directors present: Jeannie Yee; Bernard Stewart, DDS; MD; William Nicholson, MD

Absent: Michael Wallace; Jacob Eapen

Also present: Kimberly Hartz, Chief Executive Officer; Ed Fayen, Chief Operating Officer; Chris Henry, Chief Financial Officer; Tina Nunez, Vice President; Larry LaBossiere, Vice President; Paul Kozachenko, Legal Counsel; Dee Antonio, District Clerk

Guests: Sandy Bemiss, Sri Boddu, Angus Cochran, Kristin Ferguson, Erick Galleguillos, Nick Legge, Erica Luna, Dan Nardoni, Felipe Villanueva, Marcus Watkins, John Zubiena

OPENING REMARKS

Director Yee welcomed any members of the general public to the meeting. She noted that in order to continue to protect the health and safety of the members of the Board, District staff, and members of the public from the dangers posed by the SARS-CoV-2 virus, the Brown Act allows a local agency to continue to hold its meetings remotely as opposed to being required to meet in-person. Section 54953(e)(3) of the Government Code requires that the Board make certain findings every 30 days to continue meeting remotely. One such finding is that "state or local officials continue to impose or recommend measures to promote social distancing." The Alameda County Health Officer continues to recommend social distancing and the wearing of masks indoors, as referenced by the Alameda County Health Care Services Public Health Department COVID-19 website at www.covid-19.acgov.org. The Board made such a finding at its meeting earlier in the month.

Director Yee noted that Public Notice for this meeting, including connection information, was posted appropriately on our website. This meeting, conducted via Zoom, is being recorded for broadcast at a later date.

COMMUNICATIONS

There were no oral or written communications.

PRESENTATION: BUDGET ESTIMATE FY 2022-2023

Kimberly Hartz introduced Chris Henry and Erica Luna who presented the Budget Estimate for Fiscal Year 2023. Mr. Henry began with a review of the environment throughout the COVID-19 pandemic alongside a variety of significant challenges. He noted that He noted that WHHS has incorporated many operational changes that were required to operate during the early part of the pandemic into day-to-day operations and have stabilized into what we believe is a new normal. Going forward, we will focus on building the foundation for growth and success of WHHS into the future. Other items affecting our environment include the economic pressures that have resulted from pandemic-related issues and the war in Ukraine, recruitment and retention challenges, and government payor reimbursement.

The FY 2023 budget provides for:

- Total Operating and Non-Operating Revenue of $557.3M

- Funding of Capital Spending Requests of $47.3M
- Funding of Retirement Plan and Post-Retirement Healthcare Benefits of $11.2M
- Revenue Bond Debt Service of $15.7M
- Property Tax Revenue of $18.2M for General Obligation Bond Debt Service
- Net Income Targets:
    - Hospital Earnings Before Interest, Taxes, Depreciation & Amortization (EBITDA) of $67.8M
    - Hospital Operating Income of $22.5M
    - Hospital Total Net Income of $25.2M
- Funding of $23.1M in Support of Affiliate Operations
- Compliance with All Bond Requirements

Ms. Luna reviewed the FY23 budget specifics. Consisting of Income Statement,, Key Budget Assumptions, Admissions, Patient Days, Daily Census, Length of Stay, Outpatient Observation Days, Deliveries, Surgical and Cath Lab Cases, Emergency Room and Outpatient Visits, Productivity Indicators, Revenue and Expenses. Capital Spending for FY23 was reviewed.

RESOLUTION No. 1243 BUDGET ESTIMATE FY 2022-2023

In accordance with District law, policies, and procedures, Director Nicholson moved for adoption of Resolution No. 1243, which is the Budget Estimate for Fiscal Year 2022-2023. This Resolution provides for the necessary funds required for the operation of the District and for the continued support of the Washington Township Hospital Development Corporation in its operations to promote the charitable and community service mission of the District.

Director Stewart seconded the motion.

Director Yee asked if there were any comments from members of the public. There were none.

Roll call was taken:

Jeannie Yee – aye
Bernard Stewart, DDS – aye
Michael Wallace – absent
Jacob Eapen – absent
William Nicholson, MD – aye

The motion carried.

ANNOUNCEMENTS

Kimberly Hartz announced that Washington Hospital was now offering vaccinations to children aged 6 months to 5 years of age through our COVID clinic (telephone 510-248-8200).

ADJOURN TO CLOSED SESSION

In accordance with Health & Safety Code Sections 32106, 32155 and California Government Code 54956.9(d)(2), Director Yee adjourned the meeting to closed

session at 6:5 p.m., as the discussion pertained to a Report of Medical Staff and Quality Assurance Committee, Health & Safety Code section 32155 (Medical Staff Credentials Committee Report), Conference involving Trade Secrets pursuant to Health & Safety Code section 32106, and Conference with Legal Counsel – Anticipated Litigation pursuant to Government Code section 54956,9(d)(2). Director Yee stated that the public has a right to know what, if any, reportable action takes place during closed session. Since this meeting is being conducted via Zoom and we have no way of knowing when the closed session will end, the public was informed they could contact the District Clerk for the Board's report beginning June 23, 2022. She indicated that the minutes of this meeting will reflect any reportable actions.

RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION

Director Yee reconvened the meeting to open session at 8:55 pm. The District Clerk reported that during the closed session, the Board approved the Medical Staff Credentials Committee Report and denied a claim filed by Justin Dominguez and a claim filed by Annabell Quiban and Englebert Quiban on behalf of Enzo Quiban by vote of all Directors present:

Jeannie Yee
Bernard Stewart, DDS
William Nicholson, MD

ADJOURNMENT

There being no further business, Director Yee adjourned the meeting at 8:55 pm.

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Jeannie Yee
President

William Nicholson, M.D.
Secretary

Rejected under operation of law

CALL TO ORDER

A meeting of the Board of Directors of the Washington Township Health Care District was held on Monday, June 27, 2022 via Zoom. Director Yee called the meeting to order at 7:30 a.m.

ROLL CALL

Roll call was taken. Directors present: Jeannie Yee; Bernard Stewart DDS; William Nicholson, MD

Excused: Jacob Eapen MD; Michael Wallace

Also present: Shakir Hyder, MD; Prasad Kilaru, MD; Mark Saleh, MD; Tim Tsoi, MD; Jan Henstorf, MD; Kimberly Hartz, CEO; Brian Smith, MD; John Romano, MD; Dee Antonio, District Clerk

COMMUNICATIONS

There were no oral or written communications.

ADJOURN TO CLOSED SESSION

Director Yee adjourned the meeting to closed session at 7:30 a.m. as the discussion pertained to Medical Audit and Quality Assurance Matters pursuant to Health & Safety Code Sections 1461 and 32155.

RECONVENE TO OPEN SESSION & REPORT ON CLOSED SESSION

Director Yee reconvened the meeting to open session at 8:22 a.m. and reported no reportable action taken in closed session.

ADJOURNMENT

There being no further business, the meeting adjourned at 8:22 a.m.

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Jeannie Yee
President

William Nicholson, M.D.
Secretary

Washington Hospital Healthcare System

S I N C E 1 9 4 8

Memorandum

DATE: **July 6, 2022**

TO: **Kimberly Hartz**
Chief Executive Officer

FROM: **Shakir Hyder, M.D.**
Chief of Staff

SUBJECT: **Revised Medical Staff Bylaws**
Revised Medical Staff Organization Manual

At the June 14, 2022 General Medical Staff meeting, changes to the Medical Staff Bylaws and the Medical Staff Organization Manual were unanimously approved. The Documents with the redlined changes are included in this communication. The revisions to the Bylaws and Organization Manual are as follows:

- Updated language such as: changing the term Allied Health Staff to Advance Practice Providers; changing the term Peer Review to Professional Practice Evaluation; changing the term Chief of Medical Staff Services to Chief Medical Officer; and delineating further clarifications for eligibility to different medical staff categories.

- The most significant of the changes are related to the addition of another officer to the slate of officers, as well as the creation of a Leadership Development Committee to replace the previous Executive Advisory Committee. The current medical staff leadership structure includes four officers, the Chief of Staff, the Chief of Staff-Elect, the Past Chief of Staff, and the Medical Staff Liaison Officer. Given the complexities of the practice of medicine in the current environment and the collaboration and interaction needed between the medical staff and the hospital system in matters of quality and utilization management, it was recommended that an additional officer position be created to help oversee quality and utilization management at Washington Hospital in addition to the current slate of four officers. The titles for the officers are also being changed to reflect the work that is being done by them. The Chief of Staff and the Medical Staff liaison Officer will continue in their current roles and titles. The Chief of Staff Elect, who has traditionally been the Chair of the Credential and Bylaws Committee, will be designated the Chief of Credentials and Bylaws. The Past Chief of Staff, who has traditionally been the Chair of the Professional Practice Evaluation Committee, will be designated the Chief of Professional Practice Evaluation. There will be the addition of a fifth officer, the Chief of Quality and Utilization Management. In order to facilitate a smoother transition and to allow for flexibility within the roles in the officer cadre, the term of the officers would change from the current six-year term to a four-year term, with the option for a second four-year term, if the physician so chooses to run.

- The second change is the creation of the Leadership Development Committee, which will replace the previous Executive Advisory Committee. The Executive Advisory Committee, which previously consisted of four past Chiefs of Staff, made recommendations for leadership positions. The proposed new Leadership Development Committee would be a broader, more representative, and robust committee that consists of members from different

departments and groups. The goal of this Committee is to provide training to all physicians on the medical staff who are interested in pursuing a leadership position. In order to make sure that potential leaders are qualified and able to undertake the tasks required for competent and proficient leadership, the Leadership Development Committee will establish criteria and provide training for those physicians who are interested in taking on a leadership role. The Leadership Development Committee will help develop those leadership skills in any physician who may be interested in pursuing a leadership position on the Medical Staff.

Please accept this memorandum as a formal request for approval by the Board of Directors.

WASHINGTON HOSPITAL

MEDICAL STAFF

BYLAWS

May 10, 2018

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentialing Policy.

1.B. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by the Chief Executive Officer, by a Medical Staff member, or by a Medical Staff committee, the individual (or the committee through its chair) may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be set by the Medical Executive Committee and approved by the Active Staff. They may vary by category.

(2) Dues shall be payable at the beginning of each new Medical Staff year. Failure to pay dues shall result in automatic relinquishment of Medical Staff membership and clinical privileges, as well as ineligibility to apply for Medical Staff reappointment. This automatic relinquishment will be effective immediately upon Special Notice to the individual. An individual has 14 days following the automatic relinquishment to pay his or her dues. At the end of that time period, the individual is deemed to have automatically resigned in accordance with the Credentialing Policy. (In rare circumstances, the Medical Executive Committee may excuse an individual's failure to pay dues for good cause.)

(3) Signatories to the Hospital's Medical Staff account shall be the Chief of Staff, the Chief ~~Chair~~ of ~~Staff-Elect~~Credentials and Bylaws, the ~~Immediate Past Chief of Staff~~~~Chair~~Chief of Professional Practice Evaluation, ~~Chair~~Chief of Quality and Utilization Management, and the Medical Staff Liaison Officer.

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1.D. SELF GOVERNANCE

The Medical Staff is self-governing with respect to the professional work performed at the Hospital, but is ultimately responsible to the Board for the adequacy and quality of medical care rendered to patients at the Hospital.

1.E. MEDICAL STAFF COUNSEL

Upon the authorization of the Medical Executive Committee, the Medical Staff may retain and be represented by independent legal counsel, who shall be compensated through Medical Staff funds.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Medical Staff Credentialing Policy are eligible to apply for appointment to one of the categories listed below.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of those members of the Medical Staff who are involved in at least 10 patient contacts at Washington Hospital or Washington Outpatient Surgery Center during the two-year appointment term.

2.A.2. Eligibility Guidelines:

Unless an Active Staff member can demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he or she will satisfy the activity requirements of this category:

Any member who has fewer than 10 patient contacts at Washington Hospital or Washington Outpatient Surgery Center during his or her two-year appointment term will not be eligible to request Active Staff status at the time of reappointment.

The member must select and be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital.

2.A.3. Prerogatives:

Active Staff members may:

(a) admit patients;

(b) vote in general and special meetings of the Medical Staff and applicable department, section, and committee meetings;

(c) hold office, serve on Medical Staff committees, and serve as department chair, section chair, and committee chair; and

(d) exercise clinical privileges granted.

2.A.4. Responsibilities:

Active Staff members must assume all the responsibilities of the Active Staff, including (but not limited to):

(a) serving on committees, as requested;

(b) participating in the professional practice evaluation and performance improvement processes (including serving as a proctor or reviewing physician, when assigned);

(c) attending at least 50% of the Medical Staff meetings, 50% of their department meetings, and 50% of their section meetings (measured annually);

(d) accepting inpatient consultations, when requested and

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(e) paying application fees, dues, and assessments.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of those members of the Medical Staff who:

(a) are involved in fewer than 10 patient contacts at Washington Hospital or Washington Outpatient Surgery Center during the two-year appointment term;

(b) are members of the Active Staff or Associate Staff at another acute care hospital (unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement based upon the recommendations of the Medical Staff); and

(c) agree to provide quality data and other information to assist in an appropriate assessment of current clinical competence as set forth in the Credentialing Policy.

2.B.2. Eligibility Guidelines:

Any Courtesy Staff member who has more than nine patient contacts during his or her two-year appointment term will be transferred to Active Staff status.

2.B.3. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff, department and section meetings (without vote);

(b) may not hold office or serve as department chair, section chair, or committee chair (unless waived by the Medical Executive Committee and ratified by the Board);

(c) may exercise such clinical privileges as are granted;

(d) may be invited to serve on committees (with vote);

(e) must participate in the professional practice evaluation and performance improvement processes (including serving as a proctor or reviewing physician, when assigned); and

(f) must pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of those members of the Medical Staff who:

(a) are of demonstrated professional ability and expertise and provide a service not otherwise available on the Active Staff;

(b) provide services at the Hospital only at the request of other members of the Medical Staff;

(c) are members of the Active Staff or Associate Staff at another acute care hospital licensed in California (unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement); and

(d) at each reappointment time, provide quality data and other information to assist in an appropriate assessment of current clinical competence as set forth in the Credentialing Policy.

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff, in accordance with the clinical privileges granted;

(b) may attend meetings of the Medical Staff and applicable department and section meetings (without vote) and applicable committee meetings (with vote);

(c) may not hold office or serve as department chair, section chair, or committee chair (unless waived by the Medical Executive Committee and the Board);

(d) agree that they will refrain from encouraging the transfer of this Hospital's patients to other hospital facilities (unless adequate facilities, services, and staffing are unavailable at this Hospital);

(e) must participate in the professional practice evaluation and performance improvement processes (including serving as a proctor or reviewing physician, when assigned); and

(f) must pay application fees, dues, and assessments.

2.C.3. Eligibility Guidelines:

If a member of the Consulting Staff fails to have at least two patient contacts during his or her two-year appointment term, his or her Consulting Staff status will automatically terminate. The Consulting Staff member may avoid this automatic termination by providing at least two favorable references from another acute care hospital, freestanding surgery center, or recognized medical institution.

2.D. AMBULATORY STAFF

2.D.1. Qualifications:

The Ambulatory Staff shall consist of those members of the Medical Staff who desire to be associated with the Hospital for the purpose of providing ambulatory care. Ambulatory Staff members are exempt from the threshold eligibility criterion relating to recent clinical activity in an acute care hospital (as set forth at Section 2.A of the Credentialing Policy). However, they must demonstrate recent clinical activity in an ambulatory care setting (in their primary area of practice) within the past two years.

2.D.2. Prerogatives and Responsibilities:

Ambulatory Staff members:

(a) may attend meetings of the Medical Staff and applicable department and section meetings (voting only on issues that affect members of the Ambulatory Staff, as determined by the Medical Executive Committee)

(b) may not hold office or serve as department chair or section chair (unless waived by the Medical Executive Committee and ratified by the Board);

(c) may serve on committees of the Medical Staff when appointed (with vote)

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

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(e) are encouraged to communicate directly with Medical Staff members regarding the care of any patients referred, as well as to visit any such patients and record a courtesy progress note in the medical record containing relevant information from the patient's outpatient care;

(f) may review the medical records and test results (via paper or electronic access) for any patients who are referred (such review must comply with all Hospital and Medical Staff policies);

(g) are not granted clinical privileges to treat patients on an inpatient basis and may not admit or treat patients at the Hospital;

(h) may exercise any ambulatory care clinical privileges granted

(i) must participate in the professional practice evaluation and performance improvement processes (including serving as a proctor or reviewing physician, when assigned);

(j) are permitted to use the Hospital's diagnostic facilities in accordance with Hospital policy and the Medical Staff Rules and Regulations;

~~(k) may be required to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and~~

(~~l~~k) must pay application fees, dues, and assessments.

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2.E. ADMINISTRATIVE STAFF

2.E.1. Qualifications:

(a) The Administrative Staff will consist of members of the Medical Staff who are not otherwise eligible for another staff category and who are employed by or have a contract with the Hospital or Medical Staff to perform administrative activities.

(b) Administrative Staff membership will automatically terminate on the date on which the member's affiliation with the Hospital is terminated.

2.E.2. Prerogatives and Responsibilities:

Administrative Staff members:

(a) are not engaged in any clinical practice and do not have the responsibility for patient care, except as these activities may directly relate to an administrative duty;

(b) may not hold office or serve as department chair, section chair, or committee chair (unless waived by the Medical Executive Committee and ratified by the Board);

(c) may attend Medical Staff meetings; and

(d) may be invited to serve on committees (with vote).

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine at Washington ~~in this~~ Hospital after serving for more than 10 years, who are in good standing, and who have been recommended by the Medical Executive Committee.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff, department, and section meetings when invited to do so (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as department chairs, section chairs, or committee chairs (unless waived by the Medical Executive Committee and ratified by the Board); and

(f) are not required to pay application fees, dues, or assessments.

2.G. ~~ALLIED HEALTH STAFF~~ADVANCED PRACTICE PROFESSIONAL

2.G.1. Qualifications:

The ~~Allied Health Staff~~ Advanced Practice Professional is a collective term for the ~~Allied Health Professionals~~Advanced Practice Professionals ~~–~~practicing at the Hospital. The ~~Allied Health Staff~~Advanced Practice Professional is not a category of the Medical Staff, ~~isn't it part of the medical staff~~ but is included in this Article for convenient reference.

2.G.2. Prerogatives and Responsibilities:

Allied Health Staff members:

(a) may participate in Medical Staff and department meetings (without vote);

(b) may not hold office or serve as department director or committee chair;

(c) may be invited to serve on committees (with vote);

(d) must cooperate in the professional practice evaluation and performance improvement processes;

(e) may exercise such clinical privileges as are granted (in accordance with the Credentialing Policy); and

(f) must pay any applicable application fees, dues, and assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the Chief of Staff, ~~Chair~~Chief of Ceredentials and Bylaws, ~~Chair~~Chief ~~of peer review~~of Professional Practice Evaluation, ~~Chair~~Chief of Quality and Utilization Management ~~the Chief of Staff-Elect, the Immediate Past Chief of Staff,~~ and the Medical Staff Liaison Officer. The Chief of Staff successor (the designated successor) for the subsequent two years will be designated from one of the remaining four Chiefs.

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3.B. ELIGIBILITY CRITERIA

Only those members of the Active Medical Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the Medical Executive Committee and approved by the Board. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least three years

(2) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board as defined in the credentialing policy, including the grandfather clause (see, WHHS Medical Staff Credentialing Policy, 2.A.1 t.) ~~certified by an appropriate specialty board or possess comparable competence2?, as determined through the credentialing and privileging process;~~

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(3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;

(4) not presently be serving as Medical Staff officers, Board members, department chairs, section chairs, or committee chairs at any other hospital during their term of office (if serving in other capacities at this Hospital, the officer must be attentive to both time demands and potential of conflicts of interest and accept such other positions only if those issues can be reconciled);

(5) be willing to faithfully discharge the duties and responsibilities of the position and work toward the attainment of the mission and vision of the Hospital;

(6) have an understanding of the purposes and functions of the Medical Staff organization and a demonstrated willingness to assure that patient welfare always takes precedence over other concerns;

(7) have experience in a leadership position (or other involvement in performance improvement functions);

(8) have demonstrated clinical competence in their field of practice;

(9) have demonstrated ability to work well with and motivate others;

(10) have demonstrated administrative ability as applicable to the respective office; and

(11) ~~not have~~Must disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

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All such individuals(applicants) will need to be vetted and approved by the Leadership Development Committee and will be required to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the first weeks of the term of the office and on an ongoing basis as determined by the leadership development committee.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff shall:

(a) act in coordination and cooperation with the Chief Executive Officer, Chief ~~of~~ Medical ~~Services~~Officer, and the Board in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the Chief Executive Officer and the Board;

(c) be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/case management program functions delegated to the Medical Staff;

(d) call and preside at all regular and special meetings of the Medical Staff and the Medical Executive Committee, and assume responsibility for the agenda of all such meetings;

(e) appoint all committee chairs and members

(f) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(g) serve as spokesperson for the Medical Staff in external professional and public relations;

(h) recommend Medical Staff representatives to Hospital committees; and

(i) perform all functions authorized in all applicable policies, including, when appropriate, collegial intervention in the Credentialing Policy.

(j) whoever is the designated successor to the chief of staff for the subsequent two year term will assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

3.C.2. ~~Chief of Staff-Elect~~(The Chief of Credentials and Bylaws:

The Chief of Credentials and Bylaws ~~The Chief of Staff-Elect~~ shall:

~~(a) assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;~~

(a~~b~~) serve as chair of the Bylaws Committee, chair of the Credentials Committee, and member of the Joint Conference Committee; and

(b~~c~~) perform such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

~~assume all such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.~~

3.C.3. ~~Immediate Past Chief of Staff~~The Chair of ~~Peer Review~~Professional Practice Evaluation:

The ~~Chair~~Chief of Professional Practice Evaluation ~~Peer Review~~ ~~The Immediate Past Chief of Staff~~ shall:

~~(a) guide and work with the Medical Staff Liaison Officer on attending to all appropriate correspondence and notices on behalf of the Medical Staff;~~

(a~~b~~) serve as chair of the Professional Practice Evaluation Committee; and

(b~~c~~) perform such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

3.C.4 The Chief of Quality and Utilization Management:

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The Chief of Quality and Utilization Management shall:

(a) Serve as chair of Utilization Management committee and

(b) perform such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

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3.C.5. Medical Staff Liaison Officer:

The Medical Staff Liaison Officer shall:

(a) serve as an advisor and mentor to the Chief of Staff and the other officers;

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~~(a)~~(b) Will act as a liaison between the individual medical staff member and the medical staff leadership or administration.

~~(b)~~(c) be responsible for the minutes of the Joint Conference Committee and general Medical Staff meetings;

~~(c)~~(d) serve as a resource and subject matter expert to the Medical Executive Committee on matters pertaining to the Medical Staff Bylaws, Rules and Regulations, and other relevant policies (calling upon legal counsel as necessary);

~~(d)~~(e) attend to correspondence and notices on behalf of the Medical Staff (as directed by the Chief of Staff ~~and Chief of Staff-Elect~~);

(e) serve on select administrative committees (as chosen by the Chief of Staff and Chief Executive Officer), acting as the Medical Staff's liaison and participating in the development of hospital policies; and

(f) perform such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

3.D. NOMINATIONS

(1) The ~~Executive Advisory~~Leadership Development Committee shall serve as the nominating committee. It will convene at least 60 days prior to the election and will select the names of one or more qualified nominees for the relevant vacant officer positions. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall then be provided to the Medical Staff at least 30 days prior to the election.

(2) Additional nominations may be submitted to the Nominating Committee by written petition signed by at least ~~20~~ 16 percent of eligible voting staff members at least 15 days prior to the election. In order for a nomination to be added to the ballot, the

candidate must meet the qualifications in Section 3.B, in the judgment of the Leadership Development ~~Nominating~~ Committee, and be willing to serve.

(3) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Elections shall be held solely by written or electronic ballot returned to the Medical Staff Coordinator. Ballots may be returned in person, by mail, by facsimile, or by e-mail. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation.

(2) In the alternative, at the discretion of the Medical Executive Committee, candidates receiving a majority of written votes cast at an official meeting shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(3) All elections for Medical Staff officers, department chairs, and assistant chairs shall be held by secret ballot.

3.F. TERM OF OFFICE

Each officer will be elected to serve a four-year term as an officer on the leadership and will require re-election for a second four-year term. The leadership slate at the time of the election will state who will be the chief of staff for the first two years and who will be chief of staff for the subsequent two years and would also state which candidate would be holding which leadership position with the understanding that the leadership positions (except for the chief of staff position) could change over the 4 year period. Any change in the leadership positions would have to approved by the MEC. All leadership positions would need to meet established metrics on an ongoing basis to be eligible to continue in their prescribed roles.

~~Officers shall serve for a term of two years. At the conclusion of his or her term of office as Chief of Staff, the Chief of Staff will automatically assume the role of Immediate Past Chief of Staff. When the Chief of Staff office becomes vacant, the Chief of Staff-Elect automatically assumes the role.~~

3.G. REMOVAL

(1) Removal of an elected officer or member of the Medical Executive Committee may occur on the recommendation of the leadership development committee. This may be effectuated by a two-thirds vote of the Medical Executive Committee, or by a two-thirds vote of the Active Staff, or by the Board. Grounds for removal shall be:

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(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Executive Committee, the Active Staff, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

3.H. VACANCIES

The Chief of Staff Designated Successor ~~Chief-of-Staff-Elect~~ will automatically fill any vacancy in the office of Chief of Staff.

In the event there is a vacancy for any of the other officer positions, the Leadership Development ~~the office of Chief of Staff-Elect, the Executive Advisory~~ Committee will notify all voting members of the Medical Staff that it is seeking petitions for the vacant office. (The remaining Officers ~~The Medical Staff Liaison Officer~~ will handle the duties of the vacant ~~Chief-of-Staff-Elect~~ office until a nominee is selected.) Members have 20 days to respond to the Leadership Development ~~Executive Advisory~~ Committee, which will then select a nominee from the slate of petitioners. This nominee will fill the role of the vacant officer position until an election is scheduled with MEC approval.
~~Chief of Staff-Elect until the next scheduled election.~~

~~If there is a vacancy in the Medical Staff Liaison officer position, the Medical Executive Committee will choose an individual (who is not serving on the Medical Executive Committee) to fill this role until the next regular election. This individual should be familiar enough with hospital policy to discharge the duties of the position in an acceptable manner. If at all possible, this individual should also meet the eligibility criteria set forth at Section 3.B above, but the Medical Executive Committee has the discretion to waive those requirements if warranted by the circumstances.~~

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff may be organized into departments and sections, and/or clinical service lines, as listed in the Medical Staff Organization Manual. Subject to the approval of the Board, the Medical Executive Committee may create or eliminate such clinical units as are determined most appropriate to meet the needs of the community. References to "department" can be understood as references to "service line," as appropriate.

4.B. ASSIGNMENT TO CLINICAL DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to one or more clinical departments (or service lines) and to a section, if any, within such department. Assignment to a particular clinical department and section does not preclude an individual from seeking and being granted clinical privileges typically associated with another clinical department/service line.

(2) An individual may request a change in clinical department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF CLINICAL DEPARTMENTS

The clinical departments shall be organized for the purpose of implementing processes:

(1) to monitor and evaluate the quality and appropriateness of the care of patients served by the clinical departments; and

(2) to monitor the practice of all those with clinical privileges or a scope of practice in a given service area and recommend privileges to the credentials committee.

4.D. QUALIFICATIONS OF CLINICAL DEPARTMENT CHAIRS

Each clinical department chair and assistant chair shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the MEC with notification to the Board ~~the Board after considering the recommendation of the Chief of Staff~~

4.E. SELECTION AND REMOVAL OF CLINICAL DEPARTMENT CHAIRS

(1) Except as otherwise provided by contract, clinical department chairs and assistant chairs shall be elected by the voting members of the department, subject to approval by the Medical Executive Committee and the Board.

(2) Elections shall take place at the penultimate meeting of the department (measured across the Medical Staff year). At least 60 days prior to that meeting, the assistant chair will distribute notice of the election and a request for petitions.

(3) Petitions should be returned to the Leadership Development Committee ~~department chair~~ within 20 days after the request is made. The Leadership Development Committee ~~department chair~~ will then verify the qualifications of each petitioner. If the Leadership Development Committee ~~department chair~~ encounters any difficulties in evaluating a petitioner's qualifications, or if the Leadership Development Committee's ~~department chair's~~ decision is challenged by at least ~~three members(20~~16% of eligible voting members~~)~~ of the department, the ~~Executive Advisory~~Medical Executive Committee will resolve the concern.

(4) The slate of candidates will be announced at the meeting preceding the election. Nominations from the floor will not be accepted after this meeting.

(5) The election will be held by secret ballot.

(6) If a vacancy should arise in the department chair position, the assistant chair will assume the role and a special election will be held to fill the role of assistant chair. The department may adopt department-specific rules on vacancies by majority vote. The assistant chair will complete the current term and his/her scheduled term

(7) Any department chair and assistant chair ~~may be removed~~removal may occur on the recommendation of the leadership development committee. This is confirmed by a two-thirds vote of the clinical department members, subject to Board confirmation; or by a two-thirds vote of the Medical Executive Committee, subject to Board confirmation; or by the Board. Grounds for removal shall be:

(a) failure to comply with applicable policies and Bylaws;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) ~~suspected~~ conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(8) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the

department, the Medical Executive Committee, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

(9) Clinical department chairs and assistant chairs shall serve for a term of two years and may be re-elected.

4.F. DUTIES OF CLINICAL DEPARTMENT CHAIRS

Clinical department chairs (and assistant chairs in the absence of the chair) shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

(1) coordinating all clinically-related activities of the department;

(2) coordinating all administratively-related activities of the department;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE), as outlined in the ~~peer review~~professional practice evaluation and ongoing professional practice evaluation policies;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the clinical department or the Hospital;

(7) integrating the department into the primary functions of the Hospital;

(8) coordinating and integrating the services provided;

(9) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the clinical department;

(10) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(11) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) continuously assessing and improving the quality of care, treatment, and services provided within the clinical department;

(13) maintaining quality monitoring programs, as appropriate;

(14) providing for the orientation and continuing education of all persons in the clinical department;

(15) making recommendations for space and other resources needed by the department;

(16) performing all functions authorized in the Credentialing Policy, including collegial intervention efforts;

(17) reporting to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department; and

(18) assisting in preparation of such annual reports, including budgetary planning, pertaining to his or her department, as may be required by the Medical Executive Committee.

4.G. SECTIONS

4.G.1. Functions of Sections:

(a) Sections will perform the following activities:

(1) participation in the development of criteria for clinical privileges (when requested by the department chair);

(2) participation in ~~peer review~~professional practice evaluation and quality assurance; and

(3) discussion of a specific issue (at the special request of a department chair or the Medical Executive Committee).

(b) Sections may perform any of the following activities:

(1) continuing education;

(2) discussion of policy;

(3) discussion of equipment needs; and

(4) development of recommendations to the department chair or the Medical Executive Committee.

4.G.2. Selection and Removal of Section Chairs:

(a) Each section chair shall satisfy all the eligibility criteria outlined in Section 3.B of these Bylaws, unless waived by the Board after considering the recommendation of the Medical Executive Committee.

(b) Section chairs shall be selected and removed in the same manner outlined for department chairs in Section 4.E of these Bylaws.

4.G.3. Duties of Section Chairs:

The section chair shall carry out those functions delegated by the department chair, assistant chair, or the Medical Executive Committee, which may include the following:

(a) review and report on applications for initial appointment and clinical privileges;

(b) review and report on applications for reappointment and renewal of clinical privileges;

(c) evaluate individuals during the FPPE period in order to confirm the individual's competence;

(d) participate in the development of criteria for clinical privileges within the section;

(e) review and report regarding the professional performance of individuals practicing within the section;

(f) support the department chair in making recommendations regarding the coordination of sectional activities, as well as the Hospital resources necessary for the section to function effectively;

(g) submit reports to the department chair regarding the clinical privileges exercised within his or her section by members of (or applicants to) the Medical Staff; and

(h) perform such other duties commensurate with the office as may from time to time be requested by the department chair, assistant chair, Chief of Staff, or the Medical Executive Committee.

ARTICLE 5

MEDICAL STAFF COMMITTEES

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the Chief of Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws and must signify their willingness to meet basic expectations of committee membership as set forth in Section 3.B of the Organization Manual.

(2) Unless otherwise indicated, committee chairs and members shall be appointed for initial terms of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the Chief of Staff, at his or her discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the Chief Executive Officer. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the Chief of Staff, the Chief of Medical Services, and the Chief Executive Officer (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The Medical Executive Committee shall consist of the officers of the Medical Staff and the department chairs.

(b) The Chief of Staff will chair the Medical Executive Committee.

(c) The Chief Executive Officer, the Chief ~~of~~ Medical ~~Staff Affairs~~Officer, the Chief of Patient Care Services, the Chief Medical Information Officer, the Professional Practice Evaluation Officer ~~and the chair of the Quality & Resource Management Committee~~ shall be *ex officio* members of the Medical Executive Committee, without vote.

(d) The Medical Executive Committee will also include the Chair of Quality and Resource Management Committee, the Chair of the Leadership Development Committee, a representative from the Pharmacy, Nutrition, and Therapeutics committee and a representative from the Clinical Evaluation Committee, Critical Care Committee, Emergency Department, Physician Well Being, Pathology and Laboratory Services *ex officio*, without vote.

(e) Other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Executive Committee meeting (as guests, without vote) in order to assist the Medical Executive Committee in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the Medical Executive Committee.

5.D.2. Duties:

(a) The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies.

(b) The Medical Executive Committee is responsible for the following:

(1) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);

(2) recommending directly to the Board on at least the following:

(i) the Medical Staff's structure;

(ii) the mechanism used to review credentials and to delineate individual clinical privileges;

(iii) applicants for Medical Staff appointment and reappointment;

(iv) delineation of clinical privileges for each eligible individual;

(v) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(vi) the mechanism by which Medical Staff appointment may be terminated;

(vii) hearing procedures; and

(viii) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(3) consulting with administration on quality-related aspects of contracts for patient care services;

(4) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(5) providing leadership in activities related to patient safety;

(6) providing oversight in the process of analyzing and improving patient satisfaction;

(7) ensuring that, at least every five years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(8) providing and promoting effective liaison among the Medical Staff, Administration, and the Board; and

(9) performing such other functions as are assigned to it by these Bylaws, the Credentialing Policy, or other applicable policies.

5.D.3. Meetings:

The Medical Executive Committee shall meet at least once per month and shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix B of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Medical Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the Medical Executive Committee.

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the Chief of Staff and/or the Medical Executive Committee. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year begins on July 1 and ends on June 30.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

Regular meetings of the Medical Staff shall be held at least quarterly at a time and place designated by the Medical Executive Committee. A minimum of four meetings will be held yearly.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the Medical Executive Committee, or by a petition signed by at least 20% of the voting staff.

6.C. DEPARTMENT, SECTION, AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Organization Manual, the chairs of departments, sections and committees will establish the times for regular meetings. Departments or sections must hold regular meetings at least quarterly. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

6.C.2. Special Meetings:

A special meeting of any department, section or committee may be called by the chair thereof, and must be called by the chair at the written request of the Board, the Presiding Officer, the Chief of Staff, the Medical Executive Committee, or by a petition signed by not less than 20% of the voting staff members of the department, section or committee (but in no event fewer than two members).

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments, sections and committees at least

14 days in advance of the meetings. The means of notification shall be at the discretion of the Medical Staff Services Department and may be accomplished through written, electronic, or telephonic means, including, but not limited to, posting and electronic scheduling. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, a section, or a committee (other than the Medical Executive Committee) is called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). The required notice period for special meetings of the Medical Executive Committee shall be reduced to 24 hours. In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, section, or committee, those voting members present (but not fewer than three) shall constitute a quorum. Exceptions to this general rule exist for meetings of the Medical Executive Committee, Quality & Resource Management Committee, the Credentials Committee, and the Professional Practice Evaluation Committee; in those circumstances, the presence of at least 50% of the voting members of the committee shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, sections, and committees shall be by consensus when possible. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) In the discretion of the Presiding Officer (e.g., the Chief of Staff, the department chair, or the committee chair), as an alternative to a formal meeting, the voting members of the Medical Staff, a department, section, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, telephone, or other technology approved by the Chief of Staff, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the Medical Executive Committee, the Credentials Committee, and the Professional Practice Evaluation Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated (but not fewer than two). The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by e-mail, telephone conference, or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

The Davis Rules of Order shall not be binding at meetings and elections, but will be used for reference. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the Medical Executive Committee. The Board shall be kept apprised of the recommendations of the Medical Staff and its clinical departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or ~~peer review~~ professional practice evaluation information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and ~~peer review~~professional practice evaluation documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or ~~peer review~~professional practice evaluation processes, except as authorized by the Credentialing Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, section chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the District's corporate bylaws and California law.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentialing Policy in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentialing Policy.

8.B. PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable clinical department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the Medical Executive Committee. The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual is notified by the Chief of Staff of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the Medical Executive Committee. The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual is notified by the Chief of Staff of the right to request a hearing.

8.D. DISASTER PRIVILEGING

When the Emergency Operations plan has been implemented, the Chief Executive Officer or Chief of Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

8.E. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records; ?

(ii) satisfy threshold eligibility criteria;

(iii) comply with training or educational requirements;

(iv) provide requested information; or

(v) attend a mandatory meeting to discuss issues or concerns

(b) is involved or alleged to be involved in criminal activity as defined in the Credentialing Policy;

(c) makes a deliberate misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted by the Chief of Staff and/or the Medical Executive Committee.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the Medical Executive Committee, or a Medical Staff Officer is authorized to suspend or restrict all or any portion of an individual's clinical privileges.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the Chief of Staff or the Medical Executive Committee.

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(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension within three working days.

(4) The Medical Executive Committee will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Medical Executive Committee.

8.G. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is inconsistent with the Medical Staff Professionalism policy.

8.H. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless a date outside of this time frame is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members.

(3) The hearing process will be conducted in an informal manner consistent with California law; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel in accordance with California law; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Neither the Medical Executive Committee, the Medical Staff, nor the Board shall unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the Medical Executive Committee or by a petition signed by at least 33% of the voting members of the Medical Staff.

(3) All proposed amendments to these Bylaws must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall present all proposed amendments to the voting staff by written ballot or e-mail to be returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 33% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(4) The Medical Executive Committee shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

(5) All amendments shall be effective only after approval by the Board, which approval shall not be unreasonably withheld.

(6) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Chief Executive Officer within two weeks after receipt of a request.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of

practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These additional documents are the Medical Staff Credentialing Policy, the Policy on ~~Allied Health~~Advanced Practice Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Credentialing Policy or the Policy on ~~Allied Health~~Advanced Practice Professionals may be made by a majority vote of the members of the Medical Executive Committee, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments to these two documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

(3) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

(4) All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.

(5) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 25% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

(6) Adoption of, and changes to, the Credentialing Policy, Medical Staff Organization Manual, Policy on ~~Allied Health~~Advanced Practice Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(7) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations;

(b) a new policy proposed or adopted by the Medical Executive Committee; or

(c) proposed amendments to an existing policy that is under the authority of the Medical Executive Committee,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 25% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the matter shall be referred to the Joint Conference Committee (as described in the Organization Manual) for further review and disposition.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the Chief Executive Officer, who will forward the request for communication to the Chair of the Board. The Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the Chief of Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 10

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____

Approved by the Board: _____

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	**Courtesy**	**Consulting**	**Ambulatory**	**Admin.**	**Honorary**
Number of hospital contacts/2-year	≥ 10	< 9	≥ 2	N/A	N/A	N/A
Admit	Y	Y	N	N	N	N
Exercise clinical privileges	Y	Y	Y	N	N	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting	Y	P	P	P	P	P
Hold office	Y	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver

Y = Yes
N = No
P = Partial (with respect to voting, only when appointed to a committee)

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

GENERAL DOCUMENTATION REQUIREMENTS

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination is set forth in the Medical Staff Rules & Regulations, and may vary depending on the setting and the level of care, treatment, and services. At a minimum, a complete medical history and physical examination will determine whether there is anything in the patient's overall condition that would affect the planned course of the patient's treatment, addressing factors such as:

(a) patient identification;

(b) medical history, including chief complaint and details of present illness;

(c) relevant past, social, and family histories;

(d) inventory of body systems, as pertinent;

(e) summary of the patient's psychosocial needs (as appropriate to the patient's age);

(f) report of physical examination, as pertinent;

(g) information regarding allergies, immunization status (pediatrics only), and current medications;

(h) information on the conclusions or impressions drawn from the admission history and physical examination; and

(i) statement on the course of action planned for this episode of care and its periodic review, as appropriate.

H&Ps PERFORMED PRIOR TO ADMISSION

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible, or electronic copy of this report may be used in the patient's medical record, provided that the patient has been reassessed within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first. The update of the history and physical examination must reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition.

SHORT STAY AND ELECTIVE PROCEDURES

(1) History and physical examinations for short stays (i.e., same day discharge) must be dictated or documented in the record by 6:00 p.m. on the day prior to surgery.

(2) History and physical examinations for all other elective surgical and invasive procedures (except PTCA) must be dictated or documented in the record on the day prior to the procedure.

WASHINGTON HOSPITAL

MEDICAL STAFF

ORGANIZATION MANUAL

Approved by the Board on November 14, 2018, Rev. 10/14/2020

Approved by the Medical Staff on September 11, 2018, Rev. 09/08/2020

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ARTICLE 1

DELEGATION OF FUNCTIONS

When a function is to be carried out by the Chief Executive Officer, by the Chief of Staff, or by a Medical Staff committee, the individual (or the committee through its chair) may delegate performance of the function to one or more designees. When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CLINICAL

DEPARTMENTS

2.A.DEPARTMENTS

The Medical Staff will be organized into the following Departments and Sections:

DEPARTMENTS:	Anesthesiology	Medicine	Pediatrics
	Family & Community Medicine	Obstetrics and Gynecology	Radiology
			Surgery
SECTIONS:	Department of Medicine:	Cardiology	Emergency Medicine
	Department of Surgery:	Cardiac Surgery	Pathology
		General Surgery	Podiatry
		Neurosurgery (changed by MEC 3/21/05 and Board 4/13/05)	Urology
		Orthopaedic Surgery	Vascular (change by MEC 6/20/05 and Board 10/12/05)
	Department of Anesthesiology:	Pain Management	
	Department of Medicine:	Psychiatry and Behavioral Medicine	
SERVICES:	Free standing:	ICU-CCU	
	Department of Medicine:	EKG/EEG	Respiratory Care
		Renal Dialysis	

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DEPARTMENT CHAIRS

The functions and responsibilities of departments and department chairs are set forth in Article 4 of the Medical Staff Bylaws.

2.C.CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS AND DIVISIONS

(1) Clinical departments will be created and may be consolidated or dissolved by the Medical Executive Committee upon approval by the Board as set forth below.

(2) The following factors will be considered in determining whether a

clinical department should be created:

(a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in Section 4.C of the Bylaws);

(b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish department functions on a routine basis;

(c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(d) it has been determined by the Medical Staff leadership and the Chief Executive Officer that there is a clinical and administrative need for a new department; and

(e) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors will be considered in determining whether the dissolution of a clinical department is warranted:

(a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in the Bylaws and related policies;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;

(c) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as chair of the department; or

(e) a majority of the voting members of the department vote for its dissolution.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A.MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions.

(2) Procedures for the appointment of committee chairs, appointment of committee members, and terms of appointment are set forth in Section 5.B of the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee. However, other Medical Staff members may be invited to attend a particular Medical Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.

(4) Unless otherwise provided in a specific committee composition, voting members of committees are limited to voting members of the Medical Staff.

3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) be willing and able to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent upon the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid anecdotal or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual's first choice);

(9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(10) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;

(11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(12) participate in the development of an annual committee work plan and ensure that the committee plans are in alignment with the strategic goals of the Medical Staff; and

(13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

3.C.MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual will meet as necessary to accomplish its functions, and will maintain a permanent record of its findings, proceedings, and actions. Each committee will make a timely report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated in this Manual.

3.D.BYLAWS COMMITTEE

3.D.1.Composition:

(a) The ~~Chief of Staff-Elect~~ Chief of Credentials and Bylaws will serve as chair of the Bylaws Committee.

(b) Whenever possible, the Bylaws Committee will include three Past Chiefs of Staff.

(c) The Chief of Staff will appoint two other Medical Staff members to serve on this committee, subject to approval by the Medical Executive Committee. The Chief of Staff may also appoint further Medical Staff members as necessary if there are not enough Past Chiefs of Staff available to serve.

3.D.2.Duties:

The Bylaws Committee will perform the following functions:

(a) conduct periodic review of the Medical Staff Bylaws and Rules and Regulations;

(b) conduct periodic review of other policies and forms promulgated by the Medical Staff (as well as its departments and sections);

(c) submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices; and

(d) receive and evaluate (for recommendation to the Medical Executive Committee) suggestions for modifying Medical Staff Bylaws, Rules and Regulations, and/or other policies and forms.

3.D.3.Meetings and Reports:

The chair of the Bylaws Committee will determine its meeting schedule.

3.E.CANCER COMMITTEE

3.E.1.Composition:

(a) The Cancer Committee will consist of Active Staff members who represent each of the following specialties:

(i) diagnostic radiology;

(ii) medical oncology;

(iii) pathology;

(iv) radiation oncology; and

(v) surgery.

(b) Non-physician members will include:

(i) community outreach representative;

(ii) genetics representative;

(iii) oncology nurse;

(iv) palliative care representative;

(v) Administration representative(s);

(vi) quality management representative(s);

(vii) research representative;

(viii) social worker; and

(ix) tumor registrar.

(c) The committee will appoint a Cancer Liaison Physician, who will then become a member of the committee.

(d) Additional members will be appointed as needed (including urology and nurse navigator).

3.E.2.Duties:

The Cancer Committee will perform the following functions:

(a) support goal-setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities in the Hospital;

(b) appoint individual members to coordinate important aspects of the cancer program as required by the standards for accreditation (e.g., tumor board coordinator, tumor registry quality coordinator, quality improvement coordinator, psychological services coordinator, genetics professional/counselor, and palliative care team member);

(c) develop and evaluate annual goals for clinical and programmatic endeavors related to cancer care;

(d) monitor and evaluate the tumor board activities of the Hospital, including (but not limited to) determining conference frequency, multidisciplinary attendance, total case presentation, prospective case presentation, discussion of stage, prognostic indicators, treatment planning (using evidence-based treatment guidelines), and options for clinical trials;

(e) establish and implement a plan to evaluate the quality of tumor registry data and activity (on an annual basis); this plan will include procedures to monitor case

findings, accuracy of data collection, abstracting timeliness, follow-up, and data reporting; and

(f) develop and disseminate a report of patient and/or program outcomes to the public.

3.E.3.Meetings and Reports:

The Cancer Committee will meet quarterly and will publish an annual report to the Medical Executive Committee by November 1 (of the following year). It will also publish other reports on an as-needed basis.

3.F. CLINICAL EVALUATION COMMITTEE

3.F.1.Composition:

(a) The Clinical Evaluation Committee will consist of 11 members of the Active Staff.

(b) The committee will include representatives from these departments:

(i) Anesthesiology;

(ii) Family and Community Medicine;

(iii) Medicine;

(iv) OB-GYN;

(v) Pediatrics;

(vi) Radiology; and

(vii) Surgery.

(c) The chair of the Critical Care Committee will serve as a member of this committee, *ex officio*, with vote.

(d) The committee will also include a medical representative from Laboratory/Pathology and a representative from the Pharmacy. There will be additional Hospital staff and nursing representatives as deemed appropriate by the chair of this committee.

(e) The committee chair will appoint coordinators of Infection Control, Medical Records, Pharmacy & Therapeutics, and Tissue and Transfusion from among the members of this committee.

3.F.2. Duties:

The Clinical Evaluation Committee will perform the following functions:

(a) develop and maintain surveillance over a hospital-wide infection control program;

(b) develop a system for identifying, reporting, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data (as well as follow-up activities);

(c) develop and implement a preventive and corrective program designed to minimize infection hazards (including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques);

(d) develop written policies that define special indications for isolation requirements;

(e) provide advice (related to infection control) on all proposed construction;

(f) act on recommendations (related to infection control) received from the Chief of Staff, Medical Executive Committee, departments, and other committees;

(g) review the sensitivities of organisms specific to the facility;

(h) guide the Health Information Management department in its review and evaluation of medical records;

(i) review and make recommendations for Hospital and Medical Staff policies, including Rules and Regulations relating to medical records (especially on topics such as completion deadlines, retention and destruction, and means of enforcement for rule violations); and

(j) serve as a liaison with Hospital administration and medical records personnel on matters relating to medical records practices.

3.F.3. Meetings and Reports:

This committee will submit quarterly reports to the Medical Executive Committee and Quality and Resource Management Committee regarding its findings, conclusions, and recommendations. The committee will meet at least quarterly and may submit more frequent reports as appropriate to its duties. The Clinical Evaluation Committee will create a record of all actions taken, and its minutes will be maintained on file in the administrative offices of the Hospital.

3.G.CREDENTIALS COMMITTEE

3.G.1.Composition:

(a) The Credentials Committee will consist of at least seven members of the Active Staff appointed by the Chief of Staff (in consultation with the Chief of Medical Services). Members will be selected based on their interest or experience in credentialing matters. Whenever possible, at least three of these members will be past Chiefs of Staff.

(b) The Chief of Credentials and Bylaws ~~Chief of Staff-Elect~~ will serve as chair of the Credentials Committee.

(c) Members of the committee will be appointed for an initial four-year term and will be replaced on a rotating basis to promote continuity. Members may be reappointed for subsequent terms.

(d) The chair of the committee may appoint one or more representatives from the ~~Allied Health Staff~~Advanced Practice Provider to serve as a member(s) of the committee on an as-needed basis.

3.G.2.Duties:

The Credentials Committee will perform the following functions:

(a) review the credentials of all applicants for appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) collaborate with the Interdisciplinary Practice Committee on matters pertaining to the current clinical competence of individuals currently appointed to the Medical Staff or the ~~Allied Health Staff~~Advanced Practice Provider and, as a result of such review, make a written report of its findings and recommendations;

(c) recommend the numbers and types of cases to be reviewed as part of the initial competency evaluation;

(d) review and approve specialty-specific criteria for ongoing professional practice evaluation, and specialty-specific triggers that are identified by each department; and

(e) recommend to the Medical Executive Committee appropriate threshold eligibility criteria for clinical privileges, including clinical privileges or new procedures and clinical privileges that cross specialty lines.

3.G.3.Meetings and Reports:

The Credentials Committee will meet at least once per month and will make regular reports to the Medical Executive Committee on the status of pending applications (including any reasons for delay in processing an application or request). Meetings of the Credentials Committee will only be open to members of the committee, the Chief of Staff, the Chief Executive Officer, and any other persons that the chair of the Credentials Committee has authorized to be present. The presence of at least 50% of the voting members of the committee shall constitute a quorum.

3.H.CRITICAL CARE COMMITTEE

3.H.1.Composition:

(a) The Critical Care Committee will consist of at least ten members of the Active Staff, including representatives from:

(i) Anesthesiology;

(ii) Family and Community Medicine;

(iii) Medicine;

(iv) OB-GYN;

(v) Pediatrics; and

(vi) Surgery.

(b) The Medical Directors of Emergency Services and a representative from the Emergency Medical Section will be members of this committee.

(c) The Medical Directors of the ICU-CCU and of Respiratory Care will be members of this committee.

(d) Appropriate Hospital staff members will also serve on the committee.

3.H.2. Duties:

The Critical Care Committee will perform the following functions:

(a) recommend and supervise overall service policies of the ICU-CCU and Emergency Services;

(b) provide for ongoing review of equipment, physical facilities, procedures, records, and professional proficiency with the ICU-CCU and Emergency Services;

(c) serve as a liaison between the ICU-CCU, Emergency Services, and the Medical Staff;

(d) coordinate with the Emergency Department and professional staff for community agencies (e.g., civil defense, fire, police, etc.) for the order and disposition of disaster victims; and

(e) review all equipment and supplies in the code blue crash carts (for code blue responses) at least annually.

3.H.3. Meetings and Reports:

This committee will meet at least monthly and will report directly to the Quality and Resource Management Committee.

3.I.INTERDISCIPLINARY PRACTICE COMMITTEE

3.I.1. Composition:

(a) The Interdisciplinary Practice Committee will consist of at least four members of the Medical Staff appointed by the Chief of Staff.

(b) The committee will include an equal number of physician and members of the ~~Allied Health Staff~~Advanced Practice Provider, with at least one registered nurse. ~~.~~There should be an ~~Allied Health Staff~~Advanced Practice Providers ~~member~~ who would be an assistant to the chair of the committee.

3.I.2. Duties:

The Interdisciplinary Practice Committee will perform the following functions:

(a) make recommendations to the Credentials Committee regarding the credentialing body of ~~Allied Health Staff~~ Advanced Practice Providers~~members~~;

(b) establish and administer standardized procedures for registered nurses as follows:

(i) prescribe a required form for standardized procedures, including the subject to be covered;

(ii) identify the nursing functions that require the adoption of standardized procedures and ensure that registered nurses perform them only in accordance with standardized procedures;

(iii) establish a method for the review and approval of all proposed standardized procedures;

(iv) review and recommend approval of all proposed standardized procedures covering registered nurses;

(v) ensure that the Chief Nursing Officer has a system in place for identifying and designating the registered nurses who are qualified to practice under each standardized procedure, both on an initial and a continuing basis; and

(vi) ensure that the names of registered nurses approved to perform functions according to each standardized procedure are on file in the office of the Chief Nursing Officer or at some other designated place;

(c) oversee the ~~Allied Health Staff~~Advanced Practice Provider as follows:

(i) identify specific categories of ~~Allied Health Professionals~~Advanced Practice Providers and make appropriate recommendations;

(ii) make recommendations concerning the minimum standards of practice applicable to ~~Allied Health Professional~~ Advanced Practice Provider categories;

(iii) make recommendations concerning the supervision required for ~~Allied Health Professionals~~Advanced Practice Providers;

(iv) review applications for permission to practice and renewal of permission to practice and privileges granted to practitioners from accepted categories in accordance with applicable Medical Staff bylaws, rules/regulations and policies; and

(v) conduct investigations and review concerns related to the practice of ~~Allied Health~~ Peer ~~Professionals~~Advanced Practice Providers, in accordance with applicable Medical Staff bylaws, rules/regulations and policies; and

(d) review and recommend approval of standardized procedures under which Registered Nurses practice in expanded roles.

3.I.3. Meetings and Reports:

The Interdisciplinary Practice Committee will meet at least quarterly, and more often if deemed necessary by the chair. It reports to the Medical Executive Committee and (as appropriate) to the Credentials Committee.

3.J.JOINT CONFERENCE COMMITTEE

3.J.1.Composition:

(a) The Chief of Staff will serve as chair of the committee.

(b) The Joint Conference Committee will also include the Chief Executive Officer, Chief of Credentials and Bylaws, Chief of Professional Practice Evaluation, Chief of Quality and Utilization management~~Chief of Staff Elect, the Immediate Past Chief of Staff~~, the Medical Staff Liaison Officer, the Chief ~~of~~ Medical ~~Services~~Officer, Chief Nursing Officer, and two representatives from the Board of Directors.

3.J.2.Duties:

The Joint Conference Committee will perform the following functions:

(a) provide a forum for the discussion of Hospital and Medical Staff policies, as well as related matters; and

(b) provide a forum for interaction between the Administration, Board, and Medical Staff.

3.J.3.Meetings and Reports:

The Chief of Staff is responsible for the agenda of the Joint Conference Committee. It will meet at least monthly. The Medical Staff Liaison Officer will be responsible for the ~~preparation of the~~ minutes.

3.K.LEADERSHIP COUNCIL

3.K.1.Composition:

(a) The Leadership Council will consist of the following voting members:

(i) Chief of Staff, who will serve as chair;

(ii) Chief of Credentials and Bylaws~~Chief of Staff Elect~~;

(iii) Chief of Professional Practice Evaluation;

~~(iii)~~(iv) Chief of Quality and Utilization Management ~~Medical Staff Liaison Officer~~; and

~~(iv)~~(v) Medical Staff Liaison Officer ~~the Immediate Past Chief of Staff~~.

(b) The following individuals will serve as *ex officio* members, without vote, to facilitate the Leadership Council's activities:

(i) Chief ~~of~~ Medical ~~Services~~Officer;

~~(ii) Liaison Officer;~~

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~~(iii)~~(ii) Chief of Compliance;

(iii) Chief of Quality; and

~~(iv)~~

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~~(v)~~(iv) PPE Support Staff representative(s).

(c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Leadership Council meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding an issue on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.K.2.Duties:

The Leadership Council will perform the following functions:

(a) review and address concerns about practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy;

(b) review and address possible health issues that may affect a practitioner's ability to practice safely as outlined in the Practitioner Health Policy;

(c) review and address issues regarding practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy ("PPE Policy");

(d) meet, as necessary, to consider and address any situation involving a practitioner that may require immediate action;

(e) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;

~~(f) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and~~

~~(g)~~(f) perform any additional functions as may be requested by the PPEC, the Medical Executive Committee, or the Board.

3.K.3.Meetings and Reports:

The Leadership Council will collaborate with other committees as described under the Policies noted above.~~.~~

3.L. LEADERSHIP DEVELOPMENT COMMITTEE

3.L.1.Composition

i. 11 Committee Member Candidates will be by appointment by the Chief of Staff including 1 Past Chief of Staff (1 Candidate from each of the 7 departments, 1 APP, and 2 additional at large Member Candidates). Additional Committee Member Candidates can be added for consideration

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by petition signed by 30 Members of the Active Medical Staff. Final Membership will require approval by the Medical Executive Committee and ratification by vote of the Medical Staff. These 11 Committee Members will be the Voting Members.

~~i.~~ii. A Past Chief of Staff will serve as the Chair.

iii. Committee members will be selected to maximize diversity in the following categories: Physicians, Advanced Practice Professionals, gender, race, practice type (primary care vs specialties), practice location (hospital based, PAMF, WTMF, independent practice), leadership experience (WHHS leadership and leadership at other intuitions), previous leadership training. Additional non-voting Members can be added as necessary to maintain this diversity.

iv. To promote the independence of this committee, none of the voting members of the MEC (officers or department chairs) will be on this committee.

v. Additional Ad Hoc, non-voting Members can be added to help with any specific issues or problems that need to be addressed.

vi. Additional Administrative, non-voting Members will include 3 Administrative Members appointed by the CEO.

vii. Committee members will serve an initial 3 year term, with the option to serve for additional 3 year terms.

3.L~~K~~.2.Duties:

a. Leadership pipeline:

i. Identify and support the development of new medical staff leaders

Establish and implement plan to promote diversity in the medical staff leadership

ii. Establish and implement guidelines for leadership training

iii. Establish and implement a mentorship program for new leaders

b. Leadership competency and accountability:

i. Establish, implement, and oversee competencies for each leadership position (including section chairs, department chairs, committee chairs and officers). *These competencies will be pre-requisites for eligibility for medical staff leadership positions.*

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ii. Recommend compensation strategy for committee positions based on objective factors including volume of work required.

iii. Establish, implement, and oversee metrics for each leadership position. *Performance on these metrics will be pre-requisite for continuing participation in medical staff leadership.*

iv. Review qualifications of physicians that are interested in open positions. *Any physician interested in being elected to a leadership position will be eligible to do so but will need to meet the established criteria.*

v. Assist Officers with selection of specific leader roles among the leadership candidates.

~~3.K.3~~3.L.3. ~~.~~ Meetings and Reports:

The Leadership Development Committee will meet at least quarterly, and more often if deemed necessary by the chair. It reports to the Medical Executive Committee.

~~3.L.~~3.M. LONG RANGE PLANNING COMMITTEE

~~3.L.1.~~3.M.1. Composition:

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(a) The Long Range Planning Committee will consist of at least eight members of the Active Staff, plus a chair, with representation from a variety of departments and services.

(b) In addition, Hospital Administration will send a designated representative to attend the meetings.

~~3.L.2.~~3.M.2. Duties:

The Long Range Planning Committee will perform the following functions:

(a) participate in an advisory capacity to evaluate resource needs for planning clinical programs, facilities, and services;

(b) provide input on assessing service priorities and needs and on allocation of resources;

(c) participate in formal updates of the strategic plan; and

~~(d)~~ support the mission of the Hospital.

~~(d)~~ 3.~~L~~M.3. Meetings and Reports:

The Long Range Planning Committee will meet at least twice per year (or more often, as determined by the chair). In addition, it will provide an annual summary to the Medical Executive Committee and Medical Staff.

~~3.M.~~3.N. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee are set forth in Article 5 of the Medical Staff Bylaws.

~~3.N.~~3.O. PERINATAL MORBIDITY AND MORTALITY COMMITTEE

~~3.N.1.~~3.O.1. Composition:

(a) The Perinatal Morbidity and Mortality Committee will include:

(i) three obstetricians;

(ii) three pediatricians;

(iii) an anesthesiologist;

~~(iv)~~ a pathologist, and

~~(iv)~~

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(v) a consulting neonatologist.

(b) The Perinatal Morbidity and Mortality Committee will also include appropriate Hospital representatives.

~~3.N.2.~~3.O.2. Duties:

The Perinatal Morbidity and Mortality Committee will perform the following functions:

(a) guide the review and study of cases of perinatal mortality and morbidity, reviewing available data and making recommendations for the improvement of perinatal patient care; and

(b) refer cases to other committees when appropriate.

3.O~~N~~.3. Meetings and Reports:

The committee will meet at least quarterly and as often as necessary to handle cases requiring review.

~~3.O.~~3.P. PERIPHERAL VASCULAR COMMITTEE

See Page 17.1 (attached).

~~3.P~~3.Q. PHARMACY, NUTRITION, AND THERAPEUTICS COMMITTEE

~~3.P.1.~~3.Q.1Composition:

(a) The committee chair must be a member of the Active Staff.

(b) The Director of Pharmacy will be the secretary of the committee.

(c) This committee will include representatives from the following specialties:

(i) Anesthesiology;

(ii) Critical Care Services;

(iii) Infectious Disease;

(iv) Medical Oncology;

(v) Medicine;

(vi) Surgery; and

~~(vi)~~

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(vii) one At-Large Physician.

(d) If a representative from one or more of the above specialties is unavailable, the committee chair may instead select a member of the Active Staff to fill the role.

(e) The Chief of Medical Services, Medication Safety Officer, and the Director of the Nursing Service will be members of this committee. In addition, there will be representatives from:

(i) Administration;

(ii) Clinical Nutrition;

(iii) Compliance/Risk Management;

(iv) Patient Care Services;

(v) Pharmacy; and

(vi) Quality and Resource Management.

(f) The Chief of Staff may place other health professionals on this committee as he or she deems appropriate. The chair of the committee may also invite other individuals from within or outside of the organization to provide input.

~~3.P.2.~~3.Q.2.Duties:

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The Pharmacy, Nutrition, and Therapeutics Committee will perform the following functions:

~~(a)~~(g) develop written policies and procedures for establishment of safe and effective systems for procurement, storage, distribution, dispensing and use of drugs and chemicals;

~~(b)~~(h) conduct periodic evaluations of pharmaceutical services provided and make appropriate recommendations to the Medical Executive Committee and to Administration;

~~(c)~~(i) assist in the standardization and communication of nutrition approaches and processes throughout the organization (including review and approval of the nutrition care manual, clinical nutrition services, and other relevant policies and protocols);

~~(d)~~(j) develop and periodically review a formulary or drug list;

~~(e)~~(k) provide education on the use of formulary and non-formulary medications;

~~(f)~~(l) evaluate clinical data on new drugs and preparations (as requested by members of the Medical Staff) for approval for use in the Hospital;

~~(g)~~(m) initiate and direct drug use evaluation programs and studies;

~~(h)~~(n) review the results of drug use evaluation programs and studies and make appropriate recommendations to optimize drug use;

~~(i)~~(o) establish standards concerning the use and control of investigational drugs and standards for research in the use of recognized drugs;

~~(j)~~(p) monitor and evaluate adverse drug events (including drug reactions) for biologics and vaccines (as well as other medications);

~~(k)~~(q) make recommendations to prevent the occurrence of adverse drug events;

~~(l)~~(r) participate in quality improvement activities related to medication use; and

~~(m)~~(s) operate in compliance with all Hospital and Medical Staff policies on conflicts of interest.

~~3.P.3.~~ 3.Q.3. Meetings and Reports:

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The Pharmacy, Nutrition, and Therapeutics Committee will meet at least every other month (and more often if deemed necessary by the chair). At the beginning of each meeting, members will disclose conflicts of interest in accordance with Hospital and Medical Staff policies. A quorum exists whenever there is a simple majority of the physician membership and a simple majority of the administrative staff members. The committee will prepare a quarterly report of its findings, conclusions, and recommendations and will forward that report to the Medical Executive Committee and to the Quality and Resource Management Committee. It will also maintain a record of all activities it undertakes relating to its functions.

~~3.Q.~~3.R. PROFESSIONAL PRACTICE EVALUATION COMMITTEE ("PPEC")

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~~3.Q.1.~~3.R.1. Composition:

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(a) The ~~Immediate Past Chief of Staff~~ Chief of Professional Practice Evaluation will serve as the PPEC chair.

(b) The PPEC will also include:

(i) a past chair from each department;

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(ii) the Chief ~~of~~ Medical ~~Services~~Officer;

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(iii) the Director of Quality;

(iv) the Professional Practice Officer (a non-voting member who serves as a consultant to the committee); and

(v) additional Medical Staff members who are:

(1) broadly representative of the clinical specialties on the Medical Staff;

(2) interested or experienced in credentialing, privileging, ~~PPE/peer review~~ professional practice evaluation, or other Medical Staff affairs;

(3) supportive of evidence-based medicine protocols; and

(4) appointed by the Leadership Council (if they are deemed necessary).

(c) PPE Support Staff representatives will serve as *ex officio* members, without vote, to facilitate the PPEC's activities.

~~(d) If the Immediate Past Chief of Staff (or another Past Chief of Staff) is unwilling or unable to serve, the Leadership Council will appoint another former physician leader (e.g., Medical Staff Officer, department chair, or committee chair) who is experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters.~~

~~(e)~~(d) To the fullest extent possible, PPEC members will serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

~~(f)~~(e) Before any PPEC member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation, with the nature of the training to be identified by the Leadership Council or PPEC.

(f) Other Medical Staff members or Hospital personnel may be invited to attend a particular PPEC meeting (as guests, without vote) in order to assist the PPEC in its discussions and deliberations regarding an issue on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the PPEC.

~~(g)~~

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~~3.Q.2.~~ 3.R.2. Duties:

The PPEC will perform the following functions:

~~(a)~~(g) oversee the implementation of the Professional Practice Evaluation Policy ~~(Peer Review)~~ ("PPE Policy") and ensure that all components of the process receive appropriate training and support;

~~(b)~~(h) review reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

~~(c)~~(i) review, approve, and periodically update Ongoing Professional Practice Evaluation ("OPPE") data elements that are identified by individual departments and sections, and adopt Medical Staff-wide data elements;

~~(d)~~(j) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation~~/peer review~~ process;

~~(e)~~(k) identify those variances from rules, regulations, policies, or protocols which do not require physician review, but for which an Informational Letter may be sent to the practitioner involved in the case;

~~(f)~~(l) review cases referred to it as outlined in the PPE Policy;

~~(g)~~(m) develop, when appropriate, Performance Improvement Plans for practitioners, as described in the PPE Policy;

~~(h)~~(n) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;

~~(i)~~(o) work with department chairs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through educational sessions in the department or through some other mechanism; and

~~(j)~~(p) perform any additional functions as may be set forth in applicable policy or as requested by the Leadership Council, the Medical Executive Committee, or the Board.

~~3.Q.3.~~ 3.R.3. Meetings, Reports, and Recommendations:

The PPEC will meet at least quarterly to perform its duties. The PPEC chair and/or the Medical Executive Committee may direct the committee to meet more often. The PPEC will submit reports of its activities to the Medical Executive Committee ~~and the Board~~ on

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a regular basis. The PPEC's reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty, types and numbers of dispositions for the cases, listing of education initiatives based on reviews, listing of system issues identified). These reports will generally not include the details of any reviews or findings regarding specific practitioners.

~~3.R.~~3.S. QUALITY AND RESOURCE MANAGEMENT ("QRM") COMMITTEE

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~~3.R.1.~~ 3.S.1. Composition:

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~~(a)~~(q) The Chief of Staff will appoint a member of the Active Staff to serve as chair of the QRM Committee, subject to approval by the Medical Executive Committee. The chair must have ability and experience in the area of quality improvement. Unless the Chief of Staff determines otherwise, the chair will serve for a default term of two years.

~~(b)~~(r) The committee will consist of the assistant chairs of each department (unless they are not available, in which case the department may send a substitute representative).

~~(c)~~(s) The committee will include a representative from pathology.

~~(d)~~(t) The committee will also include:

(i) the chairs of the Critical Care and Clinical Evaluation Committees;

(ii) the Chief Nursing Officer;

(iii) the Chief of Compliance;

(iv) the Chief ~~of~~ Medical ~~Officer~~Services;

(v) the ~~Chief of Staff-Elect;~~Chief of Quality and Resource Management

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(vi) the Clinical Resource Management Coordinator;

(vii) the CME Coordinator;

(viii) the Director of Quality; and

(ix) the Utilization Management Coordinator.

~~(e)~~(u) Other appropriate representatives from Administration may serve *ex officio* as non-voting members of the committee.

~~3.R.2.~~ 3.S.2. Duties:

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The QRM Committee will perform the following functions:

~~(a)~~(v) assist in implementation of the Organizational Performance Improvement Plan;

~~(b)~~(w) recommend approval of Medical Executive Committee plans for maintaining quality patient care within the Hospital, which may include mechanisms for:

(i) establishing systems to identify potential problems in patient care;

(ii) setting action priorities on problem correction;

(iii) referring priority problems for assessment and corrective action to appropriate departments or committees; and

(iv) monitoring the results of quality assessment activities throughout the Hospital;

~~(c)~~(x) coordinate quality assessment activities;

~~(d)~~(y) support a consistent level of care for patients within the facility;

~~(e)~~(z) evaluate the overall Quality Assessment and Improvement Program on an annual basis for comprehensiveness, effectiveness, integration, and cost-efficiency;

~~(f)~~(aa) obtain, review, and evaluate information and raw statistical data generated by the Hospital's case management system;

~~(g)~~(bb) coordinate the educational needs of each department with the Medical Staff's overall educational plan;

~~(h)~~(cc) organize and implement educational programs for the Medical Staff, including providing speakers for Medical Staff meetings with programs designed to reach a broad audience and to represent a reasonable cross-section of the medical fields;

~~(i)~~(dd) evaluate and implement continuing medical education and training programs at the Hospital and in the community (in cooperation with the American Medical Association and the California Medical Association); and

~~(j)~~(ee) maintain a continuing audit of Medical Staff members' participation in post-graduate continuing medical education programs.

~~3.R.3.~~ 3.S.3. Meetings and Reports:

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The QRM Committee will meet at least monthly, when possible, but at least ten times per year. It will submit regular, confidential reports to the Medical Executive Committee on the quality of medical care provided and on quality review activities conducted. The presence of at least 50% of the voting members of the committee shall constitute a quorum.

~~3.S.~~3.T. UTILIZATION MANAGEMENT COMMITTEE

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~~3.S.1.~~ 3.T.1. Composition:

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~~(a)~~(ff) The Utilization Management Committee will consist of at least three physicians.

~~(b)~~(gg) Members must recuse themselves if they have provided professional care for a patient whose case is under review.

~~(c)~~(hh) The ~~Chief of Staff will appoint the~~Chief of Quality and Utilization Management will serve as chair of the Utilization Management Committee.

~~(d)~~(ii) The Chief Executive Officer will recommend one or more senior administrative representatives to also serve on this committee.

~~3.S.2.~~ 3.S.2. Duties:

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The Utilization Management Committee will perform the following functions:

~~(a)~~(jj) review the medical necessity of admissions, appropriateness of the setting, medical necessity of extended stays, and medical necessity of professional services;

~~(b)~~(kk) perform its duties in accordance with the Policy on Review of Concerns Related to Utilization;

~~(c)~~(ll) communicate the results of its studies (and other pertinent data) to the Medical Staff departments, and, where appropriate, the entire Medical Staff;

~~(d)~~(mm) make recommendations for the optimum utilization of Hospital resources and facilities (commensurate with quality care and safety); and

~~(e)~~(nn) formulate a written utilization review plan for the Hospital, subject to approval by the Medical Executive Committee and Board.

~~3.S.3.~~ 3.T.3. Meetings and Reports:

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The Utilization Management Committee will meet at least quarterly and when deemed necessary by the chair. It reports to the Medical Executive Committee and (when appropriate) to the QRM Committee.

~~3.T.~~3.U. WELLBEING COMMITTEE

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~~3.T.1.~~ 3.U.1. Composition:

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~~(a)~~(oo) The Wellbeing Committee will consist of at least three members of the Medical Staff. Members will be selected based on their experience, expertise, and willingness to serve. To the fullest extent possible, members will serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

~~(b)~~(pp) The chair will be a physician.

~~(c)~~(qq) A majority of the committee's members must be physicians.

~~(d)~~(rr) Members of this committee shall not simultaneously serve as active participants on other ~~peer review~~ professional practice evaluation or quality assurance committees.

~~3.T.2.~~ 3.U.2. Duties:

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The Wellbeing Committee will perform the following functions:

~~(a)~~(ss) serve as an identified resource within the Hospital to receive information and concerns about the health and behavior of individual practitioners, whether from third parties or upon self-referral from the practitioners themselves;

~~(b)~~(tt) provide assistance to the Leadership Council, department chairs, and/or Medical Staff officers when information and/or concerns are brought forth regarding a practitioner's health or behavior related to physical, emotional, or drug dependency-related conditions;

~~(c)~~(uu) as directed by the Leadership Council and in accordance with the Practitioner Health Policy, facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from physical, emotional, drug-related or other potentially impairing conditions;

~~(d)~~(vv) provide advice, recommendations and assistance to any practitioner who is referred (and to the referring source);

~~(e)~~(ww) aid practitioners with regaining or retaining optimal professional functioning consistent with protection of patients and with re-entry issues;

~~(f)~~(xx) monitor practitioners for compliance with monitoring agreements, treatment programs, or other conditions of continued practice;

~~(g)~~(yy) assess and determine appropriate outside assistance resources and programs for practitioners;

~~(h)~~(zz) maintain the confidentiality of the practitioner seeking referral or referred for assistance subject to the requirements of law, ethical obligation, the bylaws, or the protection of patients (however, in the event information received by the committee clearly demonstrates that the health or known or suspected impairment of a practitioner poses or might pose an unreasonable risk of harm to hospitalized patients, that information may be referred for appropriate action); and

~~(i)~~(aaa) consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities.

~~3.T.3.~~ 3.U.2 Meetings and Reports:

The Wellbeing Committee meets at least quarterly and when deemed necessary by the chair. It will provide quarterly reports to the Medical Executive Committee regarding its general activities (e.g., number of self-referrals, number of interventions, and number of physicians undergoing monitoring). These quarterly reports will not include specific or sensitive information. As appropriate, the Wellbeing Committee may also report to the Leadership Council.

3.V. PERIPHERAL VASCULAR COMMITTEE (PVC)

3.V.1. COMPOSITION

The Committee shall consist of all members of the Medical Staff who hold privileges to perform peripheral vascular procedures, ~~including the Wound Care Medical Director who is a non-voting member of the Committee~~. The chair of the committee will be assigned by the Chief of Staff. Other members may be assigned by the Chief of Staff. A quorum shall consist of at least three voting members to include at least one cardiologist, one radiologist and one vascular surgeon. {Changed by MEG 12/20/04, MEG, Gen Medical Staff 1/11/05, Board 2/9/05)

3.V.2. DUTIES

The duties of the PVC will include:

1. Assisting the Departments of Surgery, Medicine and Radiology in performing quality review of peripheral vascular cases. The review may include evaluation of individual cases based on pre- established criteria, focused studies and statistical analysis.

2. Referring all cases with quality of care concerns to the Surgery, Medicine, and

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Radiology Committees for final professional practice evaluation.

3. Making recommendations to the Departments of Surgery, Medicine and Radiology regarding policies, procedures, standard of practice and equipment.

4. Assisting the Departments of Surgery, Medicine and Radiology in reviewing the credentials of practitioners requesting privileges for peripheral vascular procedures. All credentialing and professional practice evaluation recommendations will be made by the appropriate Departmental Committee.

5. If proctorship is instituted for members requesting additional privileges, the number of proctors and the length of the proctorship period and/or the number of cases to be proctored, is at the discretion of the department chair, with consideration for the recommendation of the Peripheral Vascular Committee. (Changed by MEG 12/20/04, MEG, Gen Medical Staff 1/11/05, Board 2/9/05)

3.V.3. MEETINGS

The Committee shall meet at least quarterly or more often as necessary according to the volume of cases and credentials files requiring review. Attendance at 50% of meetings is mandatory for the members holding peripheral vascular procedures. The Committee is responsible to the Medical Executive Committee through the Departments of Surgery, Medicine, and Radiology.

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ARTICLE 4

AMENDMENTS

This Manual will be amended as set forth in Article 9 of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Adopted by the Medical Staff: September 11, 2018

Approved by the Board: November 14, 2018

~~PERIPHERAL VASCULAR COMMITTEE (PVC)~~

~~A. COMPOSITION~~

~~The Committee shall consist of all members of the Medical Staff who hold privileges to perform peripheral vascular procedures, including the Wound Care Medical Director who is a non-voting member of the Committee.~~ The chair of the committee will be assigned by the Chief of Staff. ~~Other members may be assigned by the Chief of Staff. A quorum shall consist of at least three voting members to include at least one cardiologist, one radiologist and one vascular surgeon. (Changed by MEG 12/20/04, MEG, Gen Medical Staff 1/11/05, Board 2/9/05)~~

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~~B. DUTIES~~

~~The duties of the PVC will include:~~
~~1. Assisting the Departments of Surgery, Medicine and Radiology in performing quality review of peripheral vascular cases. The review may include evaluation of individual cases based on pre- established criteria, focused studies and statistical analysis.~~

~~2. Referring all cases with quality of care concerns to the Surgery, Medicine, and Radiology Committees for final peer review.~~

~~3. Making recommendations to the Departments of Surgery, Medicine and Radiology regarding policies, procedures, standard of practice and equipment.~~

~~4. Assisting the Departments of Surgery, Medicine and Radiology in reviewing the credentials of practitioners requesting privileges for peripheral vascular procedures. All credentialing and peer review recommendations will be made by the appropriate Departmental Committee.~~

~~5. If proctorship is instituted for members requesting additional privileges, the number of proctors and the length of the proctorship period and/or the number of cases to be proctored, is at the discretion of the department chair, with consideration for the recommendation of the Peripheral Vascular Committee. (Changed by MEG 12/20/04, MEG, Gen Medical Staff 1/11/05, Board 2/9/05)~~

~~C. MEETINGS~~

~~The Committee shall meet at least quarterly or more often as necessary according to the volume of cases and credentials files requiring review. Attendance at 50% of meetings is mandatory for the members holding peripheral vascular procedures. The Committee is responsible to the Medical Executive Committee through the Departments of Surgery, Medicine, and Radiology.~~

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: **July 6, 2022**

TO: **Kimberly Hartz**
Chief Executive Officer

FROM: **Shakir Hyder, M.D.**
Chief of Staff

SUBJECT: **Revised Medical Staff Conflict of Interest Disclosure Statements**

At the June 20, 2022 Medical Executive Committee meeting, the revised Medical Staff Conflict of Interest Disclosure Statements were approved.

Please accept this memorandum as a formal request for approval by the Board of Directors.

COVER SHEET AND INSTRUCTIONS

FOR COMPLETING DISCLOSURES

In connection with your obligations as a member of the Medical Staff, you are required to review, complete, and sign the attached: "Medical Staff of Washington Hospital Conflict of Interest Policy and Conflict of Interest Disclosure" ("Medical Staff Disclosure") and the "Washington Hospital Healthcare System Conflict of Interest Disclosure Statement" ("WHHS Disclosure").

The Medical Staff Disclosure has been approved by the Medical Staff Executive Committee. The Medical Staff Disclosure includes a description of the Medical Staff Policy and a request for disclosure of potential conflicts of interest. As described in the Policy, you have certain obligations regarding Medical Staff governance, which require the disclosure and avoidance of conflicts of interest.

The WHHS Disclosure Statement has been approved by WHHS' Chief Executive Officer. As further described in the WHHS Disclosure Statement, Medical Staff members are required to disclose certain financial interests and other facts which may rise to the level of a potential conflict of interest or potentially create legal risks for you and WHHS.

This Cover Sheet and the accompanying Disclosures will be circulated to you via Survey Monkey for review, completion, and signature. If you have any questions regarding the Medical Staff Disclosure please contact: _____, in the Medical Staff Office. If you have any questions regarding WHHS Disclosure, please contact Kristin Ferguson, Chief of Compliance.

Washington Hospital Healthcare System Conflict of Interest Disclosure Statement

Pursuant to the Washington Hospital Healthcare System's Code of Professional Conduct, ("Code") [https://www.whhs.com/About/Code-of-Professional-Conduct.aspx] the Medical Staff and Allied Health Professionals have an obligation to follow the Patient First Ethic. Pursuant to Section 8 of the Code, *Avoiding Conflicts of Interest,* Medical Staff Members and Allied Health Professionals have a duty to disclose conflicts of interests and in certain instances avoid them completely.

Annually, you must report individually held Material Financial Interests and Material Financial Interests held by an Immediate Family Member. You also have continuing obligation to promptly update the information in this Disclosure Statement should there be a change in your circumstances. In completing this Disclosure Statement, please include all material details of any potential or actual conflict of interest. Accurate disclosure of the information provided by you will allow the Washington Hospital Healthcare System to implement reasonable procedures to document disclosure of your financial interest (via Epic or otherwise) and minimize the risk of a violation of legal obligations.

The following definitions apply:

a. "Immediate Family Member" means husband or wife or domestic partner; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

b. "Material Financial Interest" means that you or an Immediate Family Member have one of the following relationships:
    i. employment, consulting, or other financial arrangements, which result in payments of more than $5,000 annually, or
    ii. an ownership interest of more than 5%, or
    iii. an interest which contributes more than 5% to your annual income, or
    iv. a position as director, trustee, managing partner, officer or key employee.

c. Washington Hospital Healthcare System its subsidiaries and affiliates include: Washington Township Development Corporation ("DEVCO"), Washington Township Medical Foundation, Washington Hospital; the Taylor McAdam Bell Neuroscience Institute; Washington Radiation Oncology Center; Washington Outpatient Surgery Center; Washington Outpatient Rehabilitation Center; Washington Outpatient Catheterization Laboratory; Washington Center for Joint Replacement; the Institute for Minimally Invasive and Robotic Surgery; and Washington West, including Washington Women's Center, Outpatient Imaging Center

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Please indicate if this is an Annual or Updated Disclosure Statement by checking the appropriate box: ☐ Annual, ☐ Updated.

Conflict of Interest Disclosure Statement

1. Do you or an Immediate Family Member have Material Financial Interest in any of the following:

    a. An Ambulatory Surgery Center, a Home Health Agency, Skilled Nursing Facility, Hospital, a Hospice Provider, a Transportation Services Provider or Laboratory (including any Outpatient Laboratory or other Laboratory).

    b. Any other organization or entity not mentioned in 1.a. (excluding your individual or group practice) which provides products or services to, or which is engaged in, an existing or proposed business relationship with the Washington Hospital Healthcare System, including its subsidiaries and affiliates?

    No: ☐
    Yes: ☐
    If yes, please specify in detail (add additional pages if necessary).
    _____
    _____
    _____
    _____
    _____
    _____

2. Are you involved in any other relationship, activity or interest, which may give rise to a conflict of interest or impair your objectivity to fairly consider or adhere to the obligations described in the Code of Professional Conduct?

    No: ☐
    Yes: ☐

    If yes, please specify in detail (add additional pages if necessary).
    _____
    _____
    _____

Statement of Compliance

To my best knowledge and belief, I have accurately and completely filled out the Disclosure Statement. I understand and agree that I have a continuing responsibility to update the information contained in Disclosure Statement. If the information contained in the Disclosure Statement requires updating, I agree to promptly revise and/or submit an updated Disclosure Statement.

Name: _____ _____
(print) (signature)

Date: _____

[DRAFT] MEDICAL STAFF OF WASHINGTON HOSPITAL

CONFLICT OF INTEREST POLICY

The purpose of this Policy is to promote honest and open self-governance by the Medical Staff by reducing conflicting interests in the Medical Staff's elections or decision-making process.

As a condition to initial appointment to, and continued membership on, the Medical Staff, each practitioner agrees to disclose, in writing, to the Medical Executive Committee, on at least an annual basis, all professional, personal and financial interests or relationships which are likely influence the practitioner's position on matters of interest to the Medical Staff such as credentialing, disciplinary actions or the formulation of Medical Staff policy. Such interests include membership in a professional practice entity; ownership of, or compensation arrangement with, a patient care entity; a leadership position at Washington Hospital, at a related entity, or at any other health facility; or, ownership in or compensation arrangement with any entity which provides goods or services to Washington Hospital or to a related entity.

The Medical Staff Secretary, or the Chair of any Medical Staff clinical department section or committee, is hereby authorized to determine if a practitioner is disqualified from voting in a Medical Staff election or on a pending issue, by virtue of having a Conflict of Interest. If a practitioner disputes a disqualification decision, the practitioner may indicate how he or she would vote on the matter in question.

All disputes relating to determinations of disqualification from voting shall be resolved by a sub-committee appointed by the Medical Executive Committee according to such process as the Medical Executive Committee shall direct. All such decisions shall be final. If the subcommittee overrules a disqualification decision, the practitioner's intended vote on the matter shall be counted.

Decisions relating to disqualification from voting, are exercises of Medical Staff self-governance and do not constitute medical disciplinary action. Such decisions

do not affect practitioners' clinical privileges or practice and are not reportable to the Medical Board of California or the National Practitioner Data Bank

Conflict of Interest Disclosure:

1. I have the following ownerships, compensation arrangements or leadership positions which may create conflicts of interest in my participation in Medical Staff credentialing, peer review or other policies:

2. I hereby confirm, as a condition to appointment to or membership in the Medical Staff, that the potential conflicts disclosed above are accurate and complete.

Printed Name: Signature:

_____ _____

Date: _____

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: June 2, 2022

TO: Kimberly Hartz, Chief Executive Officer

FROM: Larry LaBossiere, Vice President and Chief Nursing Officer

SUBJECT: **CAPITAL EQUIPMENT – Neuroptics Pupillometer-NPi-300**

The Neuroptics Pupillometer System is used to assess a patient's pupil size, constriction velocity and reactivity time in order to assess and identify early changes in neurological status. This system allows increased assessment accuracy and decreases clinician subjectivity when assessing patient pupil size and other complex ocular movement.

Over the last two years, Critical Care has seen a significant increase in the neurological patient population. This has led to the need for increased technology and accuracy in order to assess and provide technologically advanced treatment to these patients. The Critical Care Unit has only four pupillometer devices. These devices are currently being shared with the growing neurological population in the Intermediate Care Unit. The addition of three new pupillometer systems to the Critical Care areas will allow greater use of these devices on a broader patient population, increased frequency of pupillary assessments and decreased clinician error.

Due to this rationale, I am recommending the three new current pupillometer systems (NPi-300) to be purchased as capital equipment at a total cost of $21,860.76 which includes tax and freight costs. This expense is not included in the FY23 budget. The Washington Hospital Foundation has agreed to provide the funds necessary to pay for the (3) NPi-300 Pupillometer Systems for the Critical Care Areas.

Washington Hospital Healthcare System

S I N C E 1 9 4 8

Memorandum

DATE: July 13, 2022

TO: Kimberly Hartz, Chief Executive Officer

FROM: Ed Fayen, Chief Operating Officer

SUBJECT: **Project: Cardiology Offices at Fremont Office Center**

There has been a need for additional office space for the Cardiology section of the Washington Township Medical Foundation since we brought the first cardiologist into the Foundation. Recently, WTMF has hired another cardiologist and it is anticipated that we will have additional cardiologists join the practice in areas such as Structural Heart. This space will be leased to WTMF.

The current office space is inadequate to meet the needs of the community and WTMF's growing cardiology practice.

The design fees were included in the fiscal year 2022 Capital Project budget. Last week, we received approval from the City of Fremont to move forward with construction. We would like to start the bidding process for this project immediately. The costs for this project are as follows:

I.	**Construction**	
	Construction	$ 2,780,668.00
	Contingency	$ 695,167.00
	Total Construction	$ 3,475,835.00
II.	**Equipment**	
	FFE	$ 312.000.00
	IT	$ 338,712.00
	Total Equipment	$ 650,712.00
III.	**Consulting Fees**	
	Design	$ 437,556.00
	Fire Alarm Design Build	$ 42,880.00
	Project Management	$ 223,400.00
	Inspection & Testing	$ 75,000.00
	City of Fremont Permits	$ 30,000.00
	Total Consulting	$ 808,836.00
	PROJECT TOTAL	**$ 4,935,383.00**

It is requested that the Board of Directors authorize the Chief Executive Officer to enter into the necessary agreements to proceed with the Cardiology Offices Project. This is an approved project in the fiscal year 2023 Capital Project budget.

Washington Hospital Healthcare System

S I N C E 1 9 4 8

Memorandum

DATE: July 8, 2022

TO: Kimberly Hartz, Chief Executive Officer

FROM: Nicholas Legge, Chief of System Operations and Support

SUBJECT: Capital Purchase – Philips EPIQ Cardiovascular Ultrasound Systems

A cardiac ultrasound or echocardiogram checks how well a heart's chambers and valves are pumping blood through the heart. An echocardiogram can help a physician diagnose heart conditions. Our Non-Invasive Cardiology department currently utilizes the Philips iE33 cardiovascular ultrasound systems. This system came to market in 2004 and we have had multiple systems in service since 2008. Production of this model stopped in 2015, and it will be at end of life at the end of this calendar year. We were approved to replace one of the units in June 2022. We are now requesting to replace the two remaining iE33 units with the Philips EPIQ CVx Ultrasound System.

In addition to currently utilizing the Philips iE33, the Operating Room has been utilizing a Philips EPIQ 7 Ultrasound system since 2014. With this capital purchase, we are also requesting to upgrade the current EPIQ 7 system. This upgrade will give the EPIQ 7 the same functionality as the EPIQ CVx systems. The new equipment and the upgrade will provide a better user experience, more advanced applications as well as improved image quality. This will also bring standardization of cardiovascular ultrasounds to the organization.

The FY 2023 Capital Budget includes $472,160 to purchase two Philips EPIQ CVx Ultrasound Systems and to upgrade the Philips EPIQ 7 system.

It is requested that the Board of Directors authorize the Chief Executive Officer to proceed with the purchase of two Philips EPIQ CVx ultrasound systems and upgrade the Philips EPIQ 7 system in the amount of $472,160.

Washington Hospital Healthcare System

SINCE 1948

Memorandum

DATE: July 8, 2022

TO: Board of Directors, Washington Township Health Care District

FROM: Kimberly Hartz, Chief Executive Officer

SUBJECT: Appointment to the Washington Township Hospital Development Corporation Board of Directors

The Washington Township Hospital Development Corporation is a public benefit (nonprofit) California Corporation which is affiliated with the District. A five-member Board of Directors governs the Washington Township Hospital Development Corporation (DEVCO). Miroslav Garcia was reappointed to the DEVCO Board in January 2022 for the 2022 calendar year. He has since retired from the DEVCO Board effective March 7, 2022. This has created a vacancy on the DEVCO Board.

Please accept this memorandum as a request that the Board of Directors appoint Pauline Weaver to fill the vacant position on the Washington Township Hospital Development Corporation Board of Directors for the remainder of the 2022 calendar year.

Washington Hospital Healthcare System

WASHINGTON HOSPITAL

MONTHLY OPERATING REPORT

May 2022

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
INDEX TO BOARD FINANCIAL STATEMENTS
May 2022

Washington Hospital Healthcare System
SINCE 1948

Memorandum

DATE: July 7, 2022

TO: Board of Directors

FROM: Kimberly Hartz, Chief Executive Officer

SUBJECT: Washington Hospital – May 2022 Operating & Financial Activity

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SUMMARY OF OPERATIONS – (Blue Schedules)

1. **Utilization – Schedule Board 3**

	May Actual	May Budget	Current 12 Month Avg.
ACUTE INPATIENT:			
IP Average Daily Census	152.1	143.9	152.9
Combined Average Daily Census	161.6	150.7	163.3
# of Admissions	856	878	809
Patient Days	4,715	4,462	4,650
Discharge ALOS	5.67	5.08	5.62
OUTPATIENT:			
OP Visits	7,451	7,857	7,667
ER Visits	4,755	4,006	4,397
Observation Equivalent Days – OP	294	211	317

Comparison of May acute inpatient statistics to those of the budget showed a lower level of admissions and a higher level of patient days. The average length of stay (ALOS) based on discharged days was above budget. Outpatient visits were lower than budget. Emergency Room visits were above budget for the month. Observation equivalent days were higher than budget.

2. **Staffing – Schedule Board 3**

Total paid FTEs were 134.8 above budget. Total productive FTEs for May were 1,394.0, 96.6 above the budgeted level of 1,297.4. Nonproductive FTEs were 38.2 above budget. Productive FTEs per adjusted occupied bed were 5.44, 0.53 below the budgeted level of 5.97. Total FTEs per adjusted occupied bed were 6.16, 0.50 below the budgeted level of 6.66.

3. **Income - Schedule Board 1**

For the month of May the Hospital realized income of $12,066,000 from operations.

Total Gross Patient Service Revenue of $197,299,000 for May was 8.0% above budget.

Deductions from Revenue of $152,525,000 represented 77.31% of Total Gross Patient Service Revenue. This percentage is just below the budgeted amount of 77.32%.

Total Operating Revenue of $45,263,000 was $3,441,000 (8.2%) above the budget.

Total Operating Expense of $33,197,000 was $7,809,000 (19.0%) below the budgeted amount. The single largest component of the positive expense variance was due to an $8.5 million reduction in pension expense, based on the actuarial valuation of the defined benefit pension plan as of December 31, 2021. The adjustment was primarily attributable to highly favorable investment performance on pension plan assets for the 2021 calendar year.

The Total Non-Operating Income of $1,554,000 for the month includes an unrealized gain on investments of $595,000 and property tax revenue of $1,441,000. Also included is an $886,000 distribution of Federal Covid Relief Funds received in May.

The Total Net Income for May was $13,620,000, which was $12,717,000 more than the budgeted income of $903,000.

The Total Net Income for May using FASB accounting principles, in which the unrealized gain on investments, net interest expense on GO bonds and property tax revenues are removed from the non-operating income and expense, was $12,798,000 compared to budgeted income of $618,000.

4. **Balance Sheet – Schedule Board 2**

Based on the 2021 pension actuarial valuation, the prepaid pension asset increased to $12.6 million and the overall plan funding percentage increased to 108 percent.

There were no other noteworthy changes in assets and liabilities when compared to April 2022.

KIMBERLY HARTZ
Chief Executive Officer

KH/CH

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
STATEMENT OF REVENUES AND EXPENSES
May 2022
GASB FORMAT
(In thousands)

May						YEAR TO DATE			
ACTUAL	BUDGET	FAV (UNFAV) VAR	% VAR.			ACTUAL	BUDGET	FAV (UNFAV) VAR	% VAR.
					OPERATING REVENUE				
$ 117,063	$ 121,090	$ (4,027)	-3.3%	1	INPATIENT REVENUE	$ 1,271,953	$ 1,290,963	$ (19,010)	-1.5%
80,236	61,629	18,607	30.2%	2	OUTPATIENT REVENUE	870,940	653,482	217,458	33.3%
197,299	**182,719**	**14,580**	8.0%	3	**TOTAL PATIENT REVENUE**	**2,142,893**	**1,944,445**	**198,448**	10.2%
(147,532)	(137,837)	(9,695)	-7.0%	4	CONTRACTUAL ALLOWANCES	(1,630,937)	(1,469,058)	(161,879)	-11.0%
(4,993)	(3,439)	(1,554)	-45.2%	5	PROVISION FOR DOUBTFUL ACCOUNTS	(36,623)	(36,593)	(30)	-0.1%
(152,525)	**(141,276)**	**(11,249)**	-8.0%	6	**DEDUCTIONS FROM REVENUE**	**(1,667,560)**	**(1,505,651)**	**(161,909)**	-10.8%
77.31%	**77.32%**			7	**DEDUCTIONS AS % OF REVENUE**	**77.82%**	**77.43%**		
44,774	**41,443**	**3,331**	8.0%	8	**NET PATIENT REVENUE**	**475,333**	**438,794**	**36,539**	8.3%
489	379	110	29.0%	9	OTHER OPERATING INCOME	5,985	4,160	1,825	43.9%
45,263	**41,822**	**3,441**	8.2%	10	**TOTAL OPERATING REVENUE**	**481,318**	**442,954**	**38,364**	8.7%
					OPERATING EXPENSES				
21,371	18,894	(2,477)	-13.1%	11	SALARIES & WAGES	222,367	203,993	(18,374)	-9.0%
(4,073)	5,957	10,030	168.4%	12	EMPLOYEE BENEFITS	50,310	64,804	14,494	22.4%
5,523	5,396	(127)	-2.4%	13	SUPPLIES	63,980	57,182	(6,798)	-11.9%
5,061	4,725	(336)	-7.1%	14	PURCHASED SERVICES & PROF FEES	56,026	52,011	(4,015)	-7.7%
1,735	2,188	453	20.7%	15	INSURANCE, UTILITIES & OTHER	19,506	21,021	1,515	7.2%
3,580	3,846	266	6.9%	16	DEPRECIATION	42,240	43,204	964	2.2%
33,197	**41,006**	**7,809**	19.0%	17	**TOTAL OPERATING EXPENSE**	**454,429**	**442,215**	**(12,214)**	-2.8%
12,066	**816**	**11,250**	1378.7%	18	**OPERATING INCOME (LOSS)**	**26,889**	**739**	**26,150**	3538.6%
26.66%	**1.95%**			19	**OPERATING INCOME MARGIN %**	**5.59%**	**0.17%**		
					NON-OPERATING INCOME & (EXPENSE)				
238	263	(25)	-9.5%	20	INVESTMENT INCOME	2,325	2,928	(603)	-20.6%
(65)	-	(65)	0.0%	21	REALIZED GAIN/(LOSS) ON INVESTMENTS	(335)	-	(335)	0.0%
(1,789)	(1,731)	(58)	-3.4%	22	INTEREST EXPENSE	(19,131)	(19,016)	(115)	-0.6%
(29)	114	(143)	-125.4%	23	RENTAL INCOME, NET	209	1,250	(1,041)	-83.3%
277	-	277	0.0%	24	FOUNDATION DONATION	1,030	1,031	(1)	-0.1%
-	-	-	0.0%	25	BOND ISSUANCE COSTS	(456)	(600)	144	24.0%
886	-	886	0.0%	25	FEDERAL GRANT REVENUE	1,039	-	1,039	0.0%
1,441	1,441	-	0.0%	26	PROPERTY TAX REVENUE	15,857	15,857	-	0.0%
595	-	595	0.0%	27	UNREALIZED GAIN/(LOSS) ON INVESTMENTS	(7,588)	-	(7,588)	0.0%
1,554	**87**	**1,467**	1686.2%	28	**TOTAL NON-OPERATING INCOME & EXPENSE**	**(7,050)**	**1,450**	**(8,500)**	-586.2%
$ 13,620	**$ 903**	**$ 12,717**	1408.3%	29	**NET INCOME (LOSS)**	**$ 19,839**	**$ 2,189**	**$ 17,650**	806.3%
30.09%	**2.16%**			30	**NET INCOME MARGIN %**	**4.12%**	**0.49%**		
$ 12,798	**$ 618**	**$ 12,180**	1970.9%	31	**NET INCOME (LOSS) USING FASB PRINCIPLES****	**$ 24,392**	**$ (948)**	**$ 25,340**	2673.0%
28.27%	**1.48%**				**NET INCOME MARGIN %**	**5.07%**	**-0.21%**		

**NET INCOME (FASB FORMAT) EXCLUDES PROPERTY TAX INCOME, NET INTEREST EXPENSE ON GO BONDS AND UNREALIZED GAIN(LOSS) ON INVESTMENTS

SCHEDULE BOARD 2

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
BALANCE SHEET
May 2022
(In thousands)

	ASSETS AND DEFERRED OUTFLOWS	May 2022	Audited June 2021
	CURRENT ASSETS		
1	CASH & CASH EQUIVALENTS	$ 24,807	$ 31,619
2	ACCOUNTS REC NET OF ALLOWANCES	81,660	73,792
3	OTHER CURRENT ASSETS	13,740	12,052
4	TOTAL CURRENT ASSETS	120,207	117,463
	ASSETS LIMITED AS TO USE		
6	BOARD DESIGNATED FOR CAPITAL AND OTHER	200,810	215,928
6	GENERAL OBLIGATION BOND FUNDS	20,024	0
7	REVENUE BOND FUNDS	6,610	6,643
8	BOND DEBT SERVICE FUNDS	20,268	32,763
9	OTHER ASSETS LIMITED AS TO USE	9,555	10,098
10	**TOTAL ASSETS LIMITED AS TO USE**	257,267	265,432
12	**OTHER ASSETS**	272,049	246,106
13	**PREPAID PENSION**	12,593	5,161
14	**OTHER INVESTMENTS**	15,175	12,163
15	**NET PROPERTY, PLANT & EQUIPMENT**	601,861	640,049
16	**TOTAL ASSETS**	**$ 1,279,152**	**$ 1,286,374**
17	**DEFERRED OUTFLOWS**	24,638	44,063
18	**TOTAL ASSETS AND DEFERRED OUTFLOWS**	**$ 1,303,790**	**$ 1,330,437**

	LIABILITIES, NET POSITION AND DEFERRED INFLOWS	May 2022	Audited June 2021
	CURRENT LIABILITIES		
1	CURRENT MATURITIES OF L/T OBLIG	$ 10,065	$ 10,930
2	ACCOUNTS PAYABLE	17,967	18,246
3	OTHER ACCRUED LIABILITIES	84,761	112,710
4	INTEREST	8,525	10,597
5	TOTAL CURRENT LIABILITIES	121,318	152,483
	LONG-TERM DEBT OBLIGATIONS		
6	REVENUE BONDS AND OTHER	202,676	211,490
6			
7	GENERAL OBLIGATION BONDS	345,644	328,564
	OTHER LIABILITIES		
11	SUPPLEMENTAL MEDICAL RETIREMENT	38,436	40,419
12	WORKERS' COMP AND OTHER	8,487	8,033
15	**NET POSITION**	544,013	524,174
16	**TOTAL LIABILITIES AND NET POSITION**	**$ 1,260,574**	**$ 1,265,163**
17	**DEFERRED INFLOWS**	43,216	65,274
18	**TOTAL LIABILITIES, NET POSITION AND DEFERRED INFLOWS**	**$ 1,303,790**	**$ 1,330,437**

Washington Hospital Healthcare System

WASHINGTON HOSPITAL
OPERATING INDICATORS
May 2022

12 MONTH AVERAGE	May ACTUAL	May BUDGET	May FAV (UNFAV) VAR	May % VAR.			YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE FAV (UNFAV) VAR	YEAR TO DATE % VAR.
						PATIENTS IN HOSPITAL				
152.9	152.1	143.9	8.2	6%	**1**	ADULT & PEDS AVERAGE DAILY CENSUS	154.1	142.9	11.2	8%
10.4	9.5	6.8	2.7	40%	**2**	OUTPT OBSERVATION AVERAGE DAILY CENSUS	10.3	6.6	3.7	56%
163.3	161.6	150.7	10.9	7%	**3**	COMBINED AVERAGE DAILY CENSUS	164.4	149.5	14.9	10%
8.0	8.5	7.5	1.0	13%	**4**	NURSERY AVERAGE DAILY CENSUS	7.9	7.6	0.3	4%
171.3	170.1	158.2	11.9	8%	**5**	TOTAL	172.3	157.1	15.2	10%
2.7	4.3	3.4	0.9	26%	**6**	SPECIAL CARE NURSERY AVERAGE DAILY CENSUS *	2.9	2.6	0.3	12%
4,650	4,715	4,462	253	6%	**7**	ADULT & PEDS PATIENT DAYS	51,609	47,861	3,748	8%
317	294	211	83	39%	**8**	OBSERVATION EQUIVALENT DAYS - OP	3,463	2,202	1,261	57%
809	856	878	(22)	-3%	**9**	ADMISSIONS-ADULTS & PEDS	8,930	9,105	(175)	-2%
5.62	5.67	5.08	0.59	12%	**10**	AVERAGE LENGTH OF STAY-ADULTS & PEDS	5.62	5.26	0.36	7%
						OTHER KEY UTILIZATION STATISTICS				
1.598	1.599	1.641	(0.042)	-3%	**11**	OVERALL CASE MIX INDEX (CMI)	1.594	1.631	(0.037)	-2%
						SURGICAL CASES				
176	173	149	24	16%	**12**	JOINT REPLACEMENT CASES	1,932	1,512	420	28%
24	22	30	(8)	-27%	**13**	NEUROSURGICAL CASES	273	267	6	2%
13	16	8	8	100%	**14**	CARDIAC SURGICAL CASES	141	110	31	28%
182	173	169	4	2%	**15**	OTHER SURGICAL CASES	1,987	1,904	83	4%
395	384	356	28	8%	**16**	TOTAL CASES	4,333	3,793	540	14%
205	196	203	(7)	-3%	**17**	TOTAL CATH LAB CASES	2,239	2,203	36	2%
121	131	127	4	3%	**18**	DELIVERIES	1,323	1,331	(8)	-1%
7,667	7,451	7,857	(406)	-5%	**19**	OUTPATIENT VISITS	84,014	82,566	1,448	2%
4,397	4,755	4,006	749	19%	**20**	EMERGENCY VISITS	48,881	42,011	6,870	16%
						LABOR INDICATORS				
1,344.9	1,394.0	1,297.4	(96.6)	-7%	**21**	PRODUCTIVE FTE'S	1,352.0	1,281.0	(71.0)	-6%
192.7	186.2	148.0	(38.2)	-26%	**22**	NON PRODUCTIVE FTE'S	192.4	173.7	(18.7)	-11%
1,537.6	1,580.2	1,445.4	(134.8)	-9%	**23**	TOTAL FTE'S	1,544.4	1,454.7	(89.7)	-6%
5.23	5.44	5.97	0.53	9%	**24**	PRODUCTIVE FTE/ADJ. OCCUPIED BED	5.21	5.95	0.74	12%
5.99	6.16	6.66	0.50	8%	**25**	TOTAL FTE/ADJ. OCCUPIED BED	5.95	6.76	0.81	12%

* included in Adult and Peds Average Daily Census