

# **MEDICAL STAFF BYLAWS**

**2020**

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# THE MEDICAL STAFF OF THE RONALD REAGAN UCLA MEDICAL CENTER BYLAWS

## PREAMBLE

These Bylaws and accompanying Rules and Regulations are adopted to provide a framework for self-governance for the organization of the Medical Staff of the Ronald Reagan UCLA Medical Center. Subject to the authority and approval of the Governing Body, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws, and associated Rules and Regulations, Policies and Procedures, in compliance with law and regulation in matters involving the quality of medical care and patient safety to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. The furtherance of medical education and research will also be more effectively approached through an organized Medical Staff. The Medical Staff is directly responsible for patient care under the ultimate responsibility of The Regents of the University of California as the Governing Body of the Ronald Reagan UCLA Medical Center. The Regents has delegated to the Chancellor who has delegated to the Vice Chancellor for Health Sciences, the responsibility to act as the Governing Body on behalf of The Regents of the University of California. These Bylaws and accompanying Rules and Regulations provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body and relations with applicants to and Members of the Medical Staff.

## ARTICLE 1 NAME AND DEFINITIONS

### Section 1.1 Name

The name of this organization shall be "The Medical Staff of the Ronald Reagan UCLA Medical Center."

### Section 1.2 Definitions

Chief Medical Officer. "Chief Medical Officer" means an Active member of the Medical Staff appointed by the Governing Body to serve as liaison between the Medical Staff and Administration. The Chief Medical Officer is appointed by the Medical Staff to serve as a voting member of the Medical Staff Executive Committee.

Chief of Staff. "Chief of Staff" means the elected chief officer of the Medical Staff.

Clinical Privileges or Privileges. "Clinical Privileges" or "Privileges" means the permission granted to licensed independent practitioners to provide patient care and includes access to those Medical Center resources including equipment, facilities, Medical Center personnel which are necessary to effectively exercise those Privileges.

Clinical Services. "Clinical Services" of the Medical Staff shall correspond to the Clinical Departments of the David Geffen School of Medicine and School of Dentistry, University of California, Los Angeles, and their organization shall be the same.

Day(s). "Day(s)" is defined to be calendar day(s).

Designees. "Designees" mean individuals acting on behalf of another individual at the request of this other individual. Unless otherwise expressly provided in these Medical Staff Bylaws and

accompanying Rules and Regulations, a reference to any of the following individuals or bodies shall include the designee of the individual or body: Chief of Staff, Chief of Service, Medical Staff Executive Committee, Credentials Committee, and the Vice Chancellor for Health Sciences.

Designees of an individual shall have all the authority, rights and privileges as the individual whom they are representing. A designee may not act on behalf of a body for any purpose where the Medical Staff Bylaws and Rules and Regulations provide for a meeting of the body for such purpose. Designees for Committees may not act on behalf of the Committee.

Executive Committee. “Executive Committee” or “Medical Staff Executive Committee” (MSEC) means the Executive Committee of the Medical Staff with the responsibilities set forth in these Bylaws.

Ex-Officio. “Ex-Officio” means service as a member of a body by virtue of an office or position held. An ex-officio appointment is without vote unless specified otherwise.

Governing Body. “Governing Body” means the Vice Chancellor for Health Sciences acting on behalf of the Regents of the University of California.

HIPAA. “HIPAA” means the Health Insurance Portability and Accountability Act of 1996.

Investigation. “Investigation” means a process specifically instigated by the Medical Staff Executive Committee, or its designees, to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff.

In Good Standing. “In good standing” means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the Bylaws, Rules and Regulations, or policies of the Medical Staff.

Medical Center. “Medical Center” means the general acute care hospital of Ronald Reagan UCLA Medical Center, including the associated ambulatory treatment areas and the Emergency Department, which are included in the general acute care hospital license.

Medical Center Director. The “Medical Center Director” functions as the “Chief Executive Officer” or “CEO” and is the Associate Vice Chancellor for Hospital Systems. The Medical Center Director is the individual appointed by the Governing Body to act on its behalf in the overall administrative management of the Medical Center.

Medical Staff. “Medical Staff” means the organizational component of the Medical Center that includes all licensed independent physicians, dentists and podiatrists who have been granted recognition as members pursuant to these Bylaws.

Medical Staff Year. “Medical Staff Year” means the period from July 1 through June 30.

Member. “Member” means, unless otherwise expressly limited, any physician (MD or DO), dentist, or podiatrist holding a current license to practice within the scope of that license who is a member of the Medical Staff.

Physician. “Physician” means an individual with an M.D. or D.O. degree who is fully licensed or registered in California under Chapter 5, Article 3 of the Business and Professions code to practice medicine in all its phases.



Practitioner. “Practitioner” means, unless otherwise expressly limited, any licensed independent practitioner, i.e. physician, dentist, podiatrist, optometrist, or clinical psychologist applying for or exercising Clinical Privileges in the Medical Center.

Prerogative. “Prerogative” means a participatory right granted, by virtue of Medical Staff category or otherwise, to a member of the Medical Staff or Allied Health Professional and exercisable subject to the conditions imposed in these Bylaws and other Medical Center and Medical Staff Policies.

Quorum. “Quorum” means the number of members of a body, that when duly assembled at a stated meeting or one that has been properly called, is legally competent to transact business. The quorum refers to the number present, not to the number voting.

Rules and Regulations. “Rules and Regulations” refers to the Medical Staff Rules and Regulations adopted in accordance with these Bylaws.

Substantial Evidence. “Substantial Evidence” means such relevant evidence as a reasonable person might accept as adequate to support a conclusion.

## **ARTICLE 2 PURPOSE AND RESPONSIBILITIES OF THE MEDICAL STAFF**

### **Section 2.1 Purpose and Responsibilities**

- 2.1.1 To strive to ensure that all patients admitted to or treated in any of the Medical Center services receive patient-focused quality care without regard to race, religion, color, ancestry, economic status, educational background, marital status, disability, sex, age, sexual orientation, national origin or source of payment.
- 2.1.2 To provide for a level of professional performance that is consistent with generally accepted standards attainable within the Medical Center's means and circumstances.
- 2.1.3 To organize and support professional education, scientific research, and community health education and support services.
- 2.1.4 To stimulate, coordinate, and analyze the professional and scientific efforts of members or groups of members of the Medical Staff, the House Staff, and the medical and dental student bodies.
- 2.1.5 To provide a means for the Medical Staff, Governing Body, and Administration to discuss issues of mutual concern.
- 2.1.6 To increase progressively the value and contribution of the Medical Center in the education and training of all students of medicine, dentistry, and allied sciences, as well as for the members of the medical and dental professions and their affiliates at large.
- 2.1.7 To initiate, develop, and adopt Medical Staff Bylaws, Rules and Regulations, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld.

- 2.1.8 To supervise and ensure compliance with these Bylaws, Rules and Regulations, Medical Staff Policies, and Medical Center policies to carry out its responsibilities for patient safety and the professional work performed in the Hospital, pursuant to the authority delegated by the Governing Body.
- 2.1.9 To provide for accountability of the Medical Staff to the Governing Body.

## **ARTICLE 3 MEMBERSHIP**

### **Section 3.1 Eligibility and Qualifications**

**3.1.1** Members of the Medical Staff shall be professionally competent physicians, dentists, or podiatrists, who continue to meet all of the qualifications, responsibilities, and requirements, set forth in these Medical Staff Bylaws and Rules and Regulations. All applicants to the Medical Staff shall be considered for membership and privileges regardless of race, color, national origin, creed, gender, handicap, age, status as a disabled veteran of the Vietnam era, medical condition (as defined in Section 12926 of the California Government Code), ancestry, marital status, citizenship (within the limits imposed by law or University policy), or sexual orientation. They shall be:

- (a) Practitioners who hold full and unrestricted licenses to practice in the State of California or who are otherwise authorized to practice pursuant to California law. The credentialing process requiring verification in writing from primary sources whenever feasible of current licensure will be followed prior to license expiration.
- (b) Practitioners who can document their background, education, training, experience, current competence, adherence to the ethics of their profession, good reputation, and physical and mental health status with sufficient adequacy to assure the Medical Staff and the Governing Body, that any patient treated by them in the Medical Center will receive quality medical care.
- (c) Practitioners who have attained American Board of Medical Specialties (ABMS) specialty certification or the equivalent thereof in the specialty that incorporates the privileges requested. Equivalency shall include, but not be limited to Board certification or equivalency of certification from another country, and shall be determined by the Chief of the Clinical Service to which the applicant seeks appointment. Exceptions to the requirement for Board certification must be substantiated by appropriate medical education and training, and extraordinary experience and reputation, endorsed by the Service Chief and presented in writing, for consideration by the Medical Staff Executive Committee through the Credentials Committee.

Associate Medical Staff members need not be Board certified at the time of application, provided they comply with provisions of Article 4.3 of these Bylaws.

Practitioners whose specialty does not have a recognized specialty Board need not be Board certified, but must document sufficient training, experience and competence.

Current members of the Medical Staff who are not Board certified may be considered for renewal of Medical Staff privileges, provided they can document sufficient training, experience and competence, and otherwise meet the requirements of Medical Staff membership. Residents who accede to the Medical Staff on completion of their residency must become Board certified pursuant to section 4.3 of these Bylaws.

- (d) Practitioners who wish to practice in a specialty other than their primary specialty must submit a clinical privilege form and documentation of necessary medical education, training and clinical experience to that Clinical Service Chief. In such instances, Board certification is not mandatory in the secondary specialty provided the individual meets all criteria established by the Clinical Service.

At the time of reappointment, a new clinical privilege form and documentation of ongoing experience, expertise and continuing education must be submitted to each appropriate Clinical Service Chief for review and approval.

- (e) Practitioners who have the interest and ability to function effectively as role models for students and members of the House Staff.
- (f) Practitioners who can provide regular and continuing care to patients.
- (g) Practitioners who satisfy such additional training and clinical experience requirements for membership as may be established by the Clinical Service to which the individual seeks appointment, subject to approval of such additional requirements by the Credentials Committee.
- (h) Practitioners whose practice falls outside the UCLA Policy on Professional Malpractice Coverage must maintain professional liability insurance coverage with limits of coverage not less \$1 million occurrence/\$3 million aggregate.
- (i) Practitioners who can document current California Drug Enforcement Administration registration (except Pathology and non-interventional Radiology).
- (j) Practitioners who obtain and continuously maintain a valid electronic mail address, notifying Medical Staff Services of any changes.
- (k) Practitioners who are eligible to participate in the Medicare, Medicaid, and other federally sponsored health programs.

**3.1.2** A practitioner who does not meet the above basic qualifications is ineligible to apply for medical staff membership, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article 8.

**3.1.3** No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, had or presently staff membership or privileges at another health care facility, or requires a hospital affiliation in

order to participate on health plan provider panels or to pursue other personal or business interests unrelated to the treatment of patients at this or a related facility.

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

### **Section 3.2 Ethics and Ethical Relations**

- 3.2.1** The Code of Ethics of the American Medical Association, the American College of Surgeons, and the University Of California Code of Conduct, as outlined in the UCLA Health System Compliance Handbook, shall govern the professional conduct of members of the Medical Staff. Each applicant to the Medical Staff shall agree to abide by this code of ethics by execution of the application.

- 3.2.2** All members of the Medical Staff shall pledge that, without the knowledge of the patient, they will not receive from, or pay to, another physician either directly or indirectly any part of the fee received for professional services. On the contrary, it shall be agreed that all fees shall be both collected and retained by the individual when permitted by the member's condition of employment by the University, or collected and disbursed as required by the Bylaws of the UCLA Medical Group and the provisions of the member's Department Group Practice Plan.

### **Section 3.3 Members' Conduct Requirements**

As a condition of membership and privileges, a Medical Staff member shall continuously meet the requirements for professional conduct established in these Bylaws. Practitioners with privileges will be held to the same conduct requirements as members.

#### **3.3.1 Disruptive and Inappropriate Conduct**

Disruptive and inappropriate Medical Staff member conduct affects or could affect the quality of patient care at the hospital and includes:

- (a) Harassment by a Medical Staff member against any individual involved with the hospital (e.g., against another Medical Staff member, house staff, hospital employee or patient) on the basis, of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation;
- (b) "Sexual harassment" defined as unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual harassment

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

- (c) Deliberate physical, visual or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the hospital; and
- (d) Inappropriate access and unauthorized release of protected health and patient information.

### **Section 3.4 Clinical and Teaching Responsibilities**

**3.4.1** Each Medical Staff member shall provide for continuity of care to their patients, shall only delegate responsibility for diagnosis or care of patients to a member who is qualified to undertake the responsibility or who is adequately supervised, shall seek consultation whenever necessary, and shall refrain from providing a substitute physician, dentist or podiatrist to perform surgical or medical services without the patient's knowledge or consent.

#### **3.4.2 Requirements for Histories and Physicals**

- (a) Histories and physicals can be conducted or updated and documented only pursuant to specific privileges granted to qualified physicians and other practitioners who are members of the Medical Staff or who have been granted temporary privileges, acting within their scope of practice.
- (b) Every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission (or registration if an outpatient procedure) is on record, in which case that history and physical will be updated within twenty-four hours of admission.

**3.4.3** Each Medical Staff member, if requested, shall be willing and able to participate in the training of undergraduate and graduate students, develop and maintain teaching skills essential to effective functioning in contact with such students, and carry out clinical and teaching responsibilities in such a way as to serve as exemplary role models for the students and members of the House Staff for the teaching programs carried on within the Medical Center.

**3.4.4** Each Medical Staff member shall meet all educational requirements for membership, such as training on computer systems, training on compliance standards such as HIPAA, and other training as required by the Medical Staff Executive Committee.

**3.4.5** To allow relevant ongoing performance assessment of the practitioner's performance within the hospital and to identify professional practice trends that impact on quality of care and patient safety, each Clinical Service shall clearly specify in writing the minimum

activity requirements which each of its Medical Staff members in each Medical Staff category must fulfill in order to retain Medical Staff privileges at the time of reappointment. To demonstrate their ability to perform requested privileges Medical Staff members shall be responsible for maintaining accurate records of their clinical activity, and shall be able to provide documentation that they meet the minimum activity requirements of their respective Clinical Services, if requested.

### **Section 3.5 Terms of Appointment**

- 3.5.1** Appointment and reappointment to the Medical Staff shall be made by the Governing Body, upon the recommendation of the Medical Staff Executive Committee. All members of the Medical Staff shall be assigned to a Service or Services which corresponds to their clinical practice specialty(ies) in the UCLA David Geffen School of Medicine and, where appropriate, the School of Dentistry, University of California, Los Angeles. The term of Medical Staff appointment and reappointment shall be for two years.
- 3.5.2** Appointment to the Medical Staff shall confer on the appointee only such privileges as are specifically granted.
- 3.5.3** Appointment to the Faculty of the School of Medicine or the School of Dentistry, University of California, Los Angeles, shall not automatically result in conferral of Medical Staff membership, nor shall appointment to the Medical Staff automatically result in a faculty appointment. Absence of a faculty appointment shall not disqualify a person from Medical Staff membership.
- 3.5.4** Neither appointment to the Medical Staff nor the granting of privileges to perform specific procedures shall confer entitlement to unrestricted use of the Medical Center or the resources thereof. Allocation of resources, including, but not limited to, patient beds and operating room time, shall be subject to administrative allocation pursuant to procedures established by authority of the Medical Center Director or the Director's delegate in consultation with the appropriate Chief of Service. For a Medical Staff member from a non-admitting Service to be granted admitting privileges, bed requirements must be discussed with the Medical Center Director and the Director of Nursing. A twenty-four hour on-call schedule must be established to ensure that all patients have an admission history and physical examination, daily progress notes, appropriate operative and discharge summaries, and continuity of patient care. Final approval will be granted by the Governing Body.

### **Section 3.6 Provisional Appointment**

Except as otherwise determined by the Governing Body, the first twelve months of the initial appointment to the Medical Staff and the initial determination of clinical privileges shall be provisional to provide an opportunity to determine the applicant's eligibility for advancement to Active membership and for exercising the clinical privileges provisionally granted. (The Service Chief, for good cause, may recommend a one-year extension of the provisional period to the second year of the initial appointment.) The applicant will participate in the Clinical Service's focused professional practice evaluation program.

## **Section 3.7 Focused Professional Practice Evaluation**

- 3.7.1** All Provisional members shall undergo a period of focused professional practice evaluation (proctoring) to evaluate their proficiency in exercising the clinical privileges provisionally granted (Ref. MS Policy and Procedure 119: Focused Professional Practice Evaluation – Proctoring). Requirements shall be established by each Clinical Service. Unless otherwise specified, the Service Chief shall be responsible for appointing proctors. All members of the Medical Staff who have themselves completed proctoring and hold unrestricted privileges to perform the procedures and/or manage the clinical cases to be proctored, regardless of Medical Staff membership category, may serve as proctors.
- 3.7.2** The Provisional member shall be responsible for ensuring that all proctoring requirements are met. The Provisional member shall immediately report to the Service Chief any perceived undue proctoring delays. If intervention by the Service Chief does not resolve the issue, the Provisional member shall present the problem in writing to the Chief of Staff for review by the Credentials Committee. Prior to advancement to Active status, a Provisional member must furnish to the Credentials Committee a statement signed by the Chief of Service to which the appointee: (1) meets all the qualifications, has discharged all the responsibilities, and has not exceeded or abused the prerogatives to which provisional appointment was made; (2) has satisfactorily demonstrated ability to exercise the clinical privileges granted; and (3) has the ability to function effectively as a role model for students and members of the House Staff. All proctoring reports shall be completed, signed by the proctor and Service Chief and furnished to the Credentials Committee prior to advancement to Active status. The failure to progress from Provisional to Active status during the two (2)-year appointment period, based on the above criteria, will constitute grounds for termination from the Medical Staff.
- 3.7.3** A Focused Professional Practice Evaluation Program established by the Clinical Service shall be required for current members requesting additional privileges, regardless of specialty or membership category. The focused professional practice evaluation for a practitioner who has been granted temporary privileges pending appointment to the Medical Staff shall begin during this period.
- 3.7.4** Reciprocal proctoring may be performed at another healthcare facility provided that: 1) it is accredited by the Joint Commission; 2) a written reciprocal proctoring agreement has been established between the Ronald Reagan UCLA Medical Center and the other institution; 3) the proctoring is carried out concurrently by a member in good standing of the other institution, who holds unrestricted clinical privileges; and 4) the practitioner being proctored is responsible for ensuring that proctoring forms from other healthcare facilities are forwarded to the Credentials Committee.

## **Section 3.8 Leaves of Absence**

- 3.8.1** If, for any reason, a Medical Staff member requires a leave of absence from clinical duties, a request must be made in writing from the practitioner to the Service Chief and forwarded to the Chief of Staff. The reason(s) for the request and the beginning and ending dates of the leave of absence must be included with the request. The Chief of Staff will review the request and either grant a formal leave of absence, deny a leave of absence, or present the request to the Credentials Committee for consideration and recommendation. The Medical Staff member and the Service Chief will be notified in writing of the decision. When a

member has been granted a formal leave of absence from clinical duties, there shall be an automatic suspension of privileges during that leave. The practitioner shall maintain all appropriate licenses and certification during the leave of absence.

- 3.8.2** Prior to returning from a leave of absence, the member must submit to the Chief of Service necessary documentation, as is appropriate. Prior to reinstating the clinical privileges of a member who is on a leave of absence, the Service Chief must forward to the Chief of Staff written verification that the member's health status and ability to carry out delineated clinical privileges have been reviewed and were not adversely affected as a result of the time away from clinical practice at the Medical Center. The Chief of Staff will review this information and either reinstate the member's privileges, deny reinstatement, or present the information to the Credentials Committee for consideration and recommendation.
- 3.8.3** If the member's term of appointment is scheduled to expire during the term of leave, reappointment must be requested in a timely manner pursuant to the relevant provisions of these Bylaws, notwithstanding the leave. If the member's appointment expired during the time when he/she was on leave, the member must submit a completed application for reappointment prior to reinstatement. Any such application shall be processed as described in these Bylaws for initial applications, except that verified credentials information that exists in the Medical Staff's files may be utilized in the credentialing process, as appropriate. Temporary privileges may be granted as provided in these Bylaws.

## **ARTICLE 4 CATEGORIES OF MEMBERSHIP**

### **Section 4.1 Categories**

The Medical Staff shall be divided into the following categories. Of these, only the Attending, Associate Attending, and Courtesy Medical Staff may admit patients to the Medical Center. All patients shall be attended by a member of one of these categories.

### **Section 4.2 Attending**

The Attending Medical Staff shall consist of faculty members of the UCLA David Geffen School of Medicine or the School of Dentistry, University of California, Los Angeles, who admit, treat, or otherwise provide services to patients in the Ronald Reagan UCLA Medical Center, Medical Center licensed clinic, or some other affiliated healthcare facility where credentialing and performance improvement/patient safety data are readily accessible for evaluation of clinical competence.

### **Section 4.3 Associate Attending**

The Associate Attending Medical Staff shall consist of practitioners who meet all of the qualifications for the Attending staff, but have not attained American Board certification in their primary specialty, or its equivalent. Upon documentation of primary specialty Board certification or its equivalent, members of the Associate Attending Staff shall be transferred to the Attending Staff. If Board Certification is not achieved within the Board Eligible Period specified by the relevant specialty board, the practitioner will forfeit Medical Staff membership, and will not be eligible to reapply until primary specialty Board certification or its equivalent is attained. Under circumstances where additional specialty board requirements or delays make it impossible for the member to meet this timeframe, an extension may be endorsed by the Service Chief and presented



in writing, for consideration by the Medical Staff Executive Committee through the Credentials Committee.

#### **Section 4.4 UCLA Community Practice Physician**

The UCLA Community Practice Physician category shall consist of licensed physicians who hold faculty appointments in the David Geffen School of Medicine, are employed by UCLA, are members of the UCLA Medical Group, and who do not have medical staff privileges at any of the three UCLA-owned hospitals. All such physicians shall be members of the Medical Staff without formal clinical privileges, and will be assigned to a Clinical Service for the purpose participating in that service's peer review, quality assurance, and performance improvement activities. UCLA Community Practice Physicians may participate as non-voting members at various Medical Staff committees at the discretion of the Chief of Staff and/or the Medical Staff Executive Committee.

#### **Section 4.5 Courtesy**

The Courtesy Medical Staff shall consist of practitioners who do not have faculty appointments at UCLA, but admit, treat, or otherwise provide services to patients in the Ronald Reagan UCLA Medical Center and/or Medical Center licensed clinic, and otherwise meet all Medical Staff Bylaw requirements unrelated to faculty responsibilities. Members of the Courtesy Staff must have attained American Board specialty certification or its equivalent upon application. Members of the Courtesy Staff must be Active, not provisional, Staff members in good standing at another accredited healthcare facility that will provide credentialing and performance improvement/patient safety data necessary for documentation of current clinical competence.

All members of the Attending, Associate Attending, and Courtesy Medical Staff shall be eligible to vote and hold office.

#### **Section 4.6 Consultant**

**4.6.1** The Consultant Medical Staff shall be limited to practitioners who serve only as consultants in their specialty field, and for whom there is a programmatic need within their Clinical Service. Members of the Consultant Staff must be Active Staff members in good standing at another accredited healthcare facility that will provide credentialing and performance improvement/patient safety data necessary for documentation of current clinical competence.

**4.6.2** Members of this category may not admit patients to the Medical Center, although temporary privileges may be granted as specified in Section 6.2 of these Bylaws. All Consultant Staff members must participate in the focused professional performance evaluation program of their assigned Clinical Service. Consultant Staff may consult on patients, write progress notes, and refer patients to the Medical Center. Members of the Consultant Staff may not admit patients, attend patients or assist with procedures, without prior approval by their Clinical Service Chief on a case-by-case basis. Consultant Staff who admit, attend or assist with procedures more than three times in one year, must request a change to Attending or Courtesy Staff and must meet all Medical Staff Bylaw requirements including minimum activity requirements established by their Clinical Service. Consultant Staff members shall have no voting rights, and may not hold office in standing or special committees or subcommittees of the Medical Staff Executive Committee.

## **Section 4.7 Teaching Only**

- 4.7.1** The Teaching Only Medical Staff shall consist of those UCLA David Geffen School of Medicine faculty members who volunteer their clinical skills only for teaching in Ronald Reagan UCLA Medical Center or Medical Center licensed clinic, and are not remunerated for patient care or professional activities at Ronald Reagan UCLA Medical Center. (A Teaching Only Medical Staff member who is remunerated must request a change to the Attending or Courtesy Staff category).
- 4.7.2** Teaching Only members may treat hospital and clinic patients only when incident to performing clinical teaching responsibilities.
- 4.7.3** Teaching Only Medical Staff members are exempt from application processing fees (provided they do not have Attending Medical Staff membership elsewhere in the UCLA Health System). They may not admit patients to the Medical Center, although temporary privileges may be granted as specified in Section 6.2 of these Bylaws. Members of this category shall have no voting rights, and may not hold office in any standing committees or subcommittees of the Medical Staff Executive Committee.
- 4.7.4** Since Teaching Only staff appointment is dependent upon having a faculty appointment, the Medical Staff appointment in this category ceases when the faculty appointment is terminated.

## **Section 4.8 Resident/House Staff**

### **4.8.1 Qualifications**

Resident Medical Staff membership shall be held by post-doctoral trainees (Residents and Fellows) in training programs approved by the Graduate Medical Education Committee and who are licensed with the appropriate State of California licensing board. All Resident Medical Staff members must obtain a license to practice medicine within the State of California by statute. Licensing of dental residents must be in accord with the California Dental Practice Act.

### **4.8.2 Appointment**

Post-doctoral trainees who are enrolled in accredited residency training programs and who meet the above qualifications shall be appointed to the Resident Medical Staff.

- (a) Members of the Resident Staff are not eligible to hold Medical Staff office, but may participate in the activities of the Medical Staff through membership on Medical Staff committees, with the right to vote within committees if specified at the time of appointment, and non-voting attendance at medical staff meetings.
- (b) Appointment to the Resident Medical Staff shall be concurrent with their appointment in a program approved by the UCLA Graduate Medical Education Committee. Resident Medical Staff membership may not be considered as the observational period required to be completed by provisional staff. Resident Medical Staff membership terminates automatically with termination from the training program.

## **Section 4.9 Medical Students**

Medical Students are not eligible for Medical Staff membership, but any student from an accredited training program may enter notes in the medical record as long as they are countersigned by an Attending or Resident member of the Medical Staff.

## **Section 4.10 Administrative Staff**

**4.10.1** Administrative Staff membership shall be open to any physician, dentist or podiatrist who is clinically inactive within the Medical Center, but is retained by the Clinical Service to perform ongoing administrative activities related to performance improvement and patient safety. Administrative Staff shall be considered for appointment only upon recommendation of the Service Chief.

**4.10.2** The Administrative Staff shall consist of members who:

- (a) Are charged with assisting the medical center in carrying out administrative functions utilizing their medical expertise.
- (b) Document their (1) current licensure, (2) adequate experience, education and training, (3) current competence, (4) good judgment, and (5) physical and mental health status, so as to demonstrate to the satisfaction of the Credentials Committee that they are professionally and ethically competent to exercise their duties;
- (c) Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the performance improvement and patient safety functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

**4.10.3** The Administrative Staff shall be entitled to attend meetings of the Medical Staff, including open committee meetings and educational programs.

**4.10.4** Administrative Staff members shall not be eligible to vote or hold office in the Medical Staff organization. Administrative staff members may on occasion have temporary privileges in accordance with Article 6.2 of these Bylaws.

## **ARTICLE 5 INITIAL APPOINTMENT, REAPPOINTMENT, AND TERMINATION**

### **Section 5.1 Basis for Initial Appointment**

Recommendations for appointment to the Medical Staff and for granting privileges shall be based upon appraisal of all information provided in the practitioner's application (including, but not limited to, health status and written peer review recommendations regarding the practitioner's current proficiency with respect to the Medical Center's general competencies, the practitioner's training, experience, and professional performance at the Medical Center, if applicable, and in other settings, whether the practitioner meets the qualifications and can carry out all of the responsibilities specified in these Medical Staff Bylaws and Rules and Regulations, and upon the Medical Center's patient care needs and ability to provide adequate support services and facilities for the practitioner). Recommendations from peers in the same professional discipline as the

practitioner, and who have personal knowledge of the applicant, are to be included in the evaluation of the practitioner's qualifications.

## **Section 5.2 Procedure for Initial Appointment**

### **5.2.1 Application Form**

All requests to apply for membership to the Medical Staff shall be in writing, submitted on the prescribed form, shall be signed by the applicant, and shall be submitted to the Medical Staff for credentials verification and processing. The information shall be verified and evaluated by the Medical Staff using the procedures and standards set forth in the Bylaws. Following its review, the Medical Executive Committee shall recommend to the Governing Body whether to appoint and grant specific privileges. The appointment process shall be completed within 180 days following submission of a completed, signed application.

### **5.2.2 Content**

A completed application shall include, at a minimum, the following:

- (a) A statement that the applicant agrees, without regard to the action taken on the application, to be bound by the terms of the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, and policies of the Medical Center.
- (b) Detailed information concerning the applicant's qualifications, including education, training, clinical and teaching experience, specialty board status, current licensure, continuing education that is relevant to the privileges requested, current Drug Enforcement Administration registration, current health status as it relates to the applicant's clinical activities, and other information in satisfaction of the basic qualifications for membership and of any additional qualifications established by the Clinical Service to which the applicant seeks appointment.
- (c) Specific requests stating the staff category, Clinical Service, and clinical privileges for which the applicant wishes to be considered.
- (d) The applicant's specialty training program, and the names and addresses of at least two (2) peers who have known the applicant for at least one year, worked with the applicant and observed the applicant's professional performance and who can provide information regarding the applicant's clinical ability, ethical character, and ability to work with others so as not to adversely affect patient care.
- (e) Information regarding whether the: (a) applicant's license to practice medicine in any jurisdiction or DEA registration has ever been denied, revoked, suspended, restricted, reduced, not renewed, voluntarily or involuntarily relinquished, or if such action is pending, (b) applicant's Medical Staff membership or privileges at any hospital or health care facility has ever been voluntarily or involuntarily denied, revoked, suspended, restricted, reduced, not renewed, or if such action is pending, (c) applicant has voluntarily or involuntarily relinquished licensure or Medical Staff membership or privileges at any hospital or health care facility to avoid disciplinary action, (d) applicant has been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization, or if such action is pending, (e) applicant has had any judgments or settlements in professional liability

cases or claims, or if there are such cases or claims pending, or (f) applicant's health status may impair their ability to perform patient care privileges requested or Medical Staff membership responsibilities. If any of items (a) – (f) apply, the details thereof shall be included.

- (f) A statement that the applicant carries at least the minimum amount of professional liability insurance coverage as required by the Medical Staff and information on the applicant's malpractice experience during the past five years, including a consent to release of information by the applicant's present and past malpractice carriers.
- (g) Information regarding receipt of written notice of any adverse action against the applicant under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.
- (h) A statement notifying the applicant of the scope and extent of the authorization and release provisions of Section 5.8 hereof.

### **5.2.3 Incomplete Application**

- (a) A practitioner whose appointment or reappointment application is not fully completed as defined above shall not be entitled to a credentialing recommendation from any Clinical Service or Committee. If the practitioner fails to complete the application within 180 days or within 30 days of a request for additional information, whichever is later, the credentialing process may be terminated at the discretion of the Credentials Committee, after giving the applicant an opportunity to be heard, either in writing or in person as determined by the Credentials Committee. Termination of the credentialing process pursuant to this section shall not entitle the practitioner to a hearing described in Article 8 of these Bylaws.
- (b) If the applicant has not responded to a request for information within the 180 day period, the credentialing process may be terminated at the discretion of the Credentials Committee, as provided above. The applicant may apply again and any information gathered during the initial process may be used if still valid and timely.
- (c) An applicant may be given an opportunity to render an incomplete application complete as described above. However, it is the applicant's responsibility to review the application carefully and verify that the information provided in it, or as part of it, is accurate and complete before it is submitted. Any substantial misrepresentation or misstatement in, or omission from, an application shall, itself alone, constitute cause for denial of the application. Similarly, in the event that any substantial misrepresentation or misstatement in, or omission from, an application is discovered after the application has been approved; it shall constitute cause for summary suspension and/or immediate revocation of Medical Staff membership and/or all clinical privileges. This provision may be invoked by the Medical Executive Committee, at its discretion, after giving the applicant an opportunity to address the issues in writing or at a meeting.
- (d) Until notice is received from the Governing Body regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing

the Medical Staff in writing of any material change in the information provided or of any new information that might reasonably have an effect on the applicant's candidacy. Failure to meet this responsibility will be grounds for denial of the application, nullification of an approval if granted, and/or immediate termination of Medical Staff membership.

#### **5.2.4 Verification by the Medical Staff**

The Medical Staff shall expeditiously seek to verify the applicant's qualifications, including education, training, clinical competence, specialty Board status, National Practitioner Data Bank status, professional liability status, current licensure, current Drug Enforcement Administration registration, Education Commission for Foreign Medical Graduates (ECFMG) certification (where applicable), and other information in satisfaction of the basic qualifications for membership in writing and from the primary source whenever feasible. In addition, the Medical Staff shall seek to verify additional qualifications established by the Clinical Service to which the applicant is applying. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When collection and verification is accomplished the application shall be forwarded to the Service Chief. If the entire appointment process has not been completed, including final approval by the Governing Body within 180 days from the date the applicant signed the application, the Medical Staff shall obtain a signed attestation from the applicant, including current health status as it relates to the applicant's clinical activities, either affirming that all of the data on the application are still accurate, or accompanied by any required updated information.

#### **5.2.5 Chief of Service Recommendation**

The Chief of each Service in which the candidate seeks clinical privileges shall, within thirty (30) days of receipt of the completed application, provide the Credentials Committee with specific written recommendations as to whether appointment should be granted and, if so, the clinical privileges for which the applicant is qualified, together with pertinent references and background material, in accordance with 5.2.2(e) above. If the recommendation of a Chief of Service is that appointment or clinical privileges should not be granted, the recommendation shall be accompanied by a written statement setting forth the reason(s) why membership and/or clinical privileges should not be granted.

#### **5.2.6 Credentials Committee Recommendation**

Within thirty (30) days of receipt of the recommendation of the Chief(s) of Service, the Credentials Committee shall determine whether to recommend that the applicant be provisionally appointed to the Medical Staff, that the applicant be rejected for Medical Staff membership, or that the applicant's application be deferred for further consideration. The Credentials Committee, in reviewing applications and in formulating its recommendation to the Medical Staff Executive Committee, shall consider: (1) on the basis of information from (i) the Chief of Service to which the applicant seeks appointment, and (ii) the Director of the Medical Center, whether the Medical Center could provide adequate facilities and supportive services for the applicant and the patients of the applicant and, (2) on the basis of information from the Chief of Service, whether the applicant's appointment would be consistent with the clinical and educational standards of the Clinical Service. All recommendations to appoint shall include recommendations as to which clinical privileges shall be granted. When the recommendation of the Credentials Committee is to defer the application for further consideration, it shall be followed up at the next regular meeting

of the Committee with a recommendation for provisional appointment with specific clinical privileges or for rejection for Staff membership.

### **5.2.7 Medical Staff Executive Committee Recommendation**

- (a) Recommendation by the Medical Staff Executive Committee shall occur no more than thirty (30) days after the Credentials Committee makes its recommendation regarding a completed application.
- (b) If recommendations are not received by the Credentials Committee without undue delay from the Services in which clinical privileges are requested, the Credentials Committee shall make its own recommendation to the Medical Staff Executive Committee on the basis of its own evaluation employing the same type of information usually considered by Chiefs of Service.

## **Section 5.3 Basis for Reappointment**

**5.3.1** Recommendations for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member's health status, current proficiency in the Medical Center's general competencies in light of his / her performance at the Medical Center. This reappraisal is to include confirmation of adherence to Medical Staff membership requirements as stated in these Bylaws, the Medical Staff Rules and Regulations, and the Medical Staff/Medical Center Policies and Procedures.

**5.3.2** Each reappointment reappraisal shall include relevant member-specific information from ongoing practice evaluations, focused professional performance evaluations (if any), performance improvement activities, and where appropriate, comparisons to aggregate information about performance, judgment and clinical or technical skills, and reappraisal of the Medical Center's patient care needs and ability to provide adequate support services and facilities for the practitioner. Specifically, the Medical Staff shall evaluate the privilege-specific competencies of its members through its ongoing professional practice evaluation program (Ref. MS Policy and Procedure: Professional Practice Evaluation) and by formal assessment at the time of each two (2)-year reappointment.

**5.3.3** In order for the Medical Staff to carry out the above-referenced peer review and performance evaluation obligations, each practitioner will be required to perform a minimum number of cases at the Medical Center. Each Clinical Service shall be responsible for establishing the minimum clinical activity requirements for its members in accordance with these Bylaws, the Rules and Regulations and Medical Staff policies.

## **Section 5.4 Procedure for Reappointment**

### **5.4.1 Application Form**

At least six (6) months prior to the first day of the next reappointment cycle, each Medical Staff member shall be invited to apply for reappointment. All applications for reappointment shall be completed in writing on the prescribed form, signed and returned by the applicant to the Medical Staff for processing within twenty-one (21) days after receipt of the reappointment invitation. The reappointment process shall be completed within 180 days following submission of a completed, signed application.

## 5.4.2 Content

The application form for Medical Staff membership shall include:

- (a) A statement that the member agrees, without regard to the action taken on the application, to be bound by the terms of the Medical Staff Bylaws and Rules and Regulations, Policies and Procedures, policies of the Clinical Service or Division, and policies of the Medical Center.
- (b) Detailed information concerning the member's qualifications, including clinical experience, relevant practitioner-specific data compared to aggregate data if such data are available for that practitioner, specialty board status, current licensure, continuing education that is relevant to the privileges requested, current Drug Enforcement Administration registration, current health status as it relates to the member's clinical activities, and other information in satisfaction of the qualifications for continuing membership and of additional qualifications established by the Clinical Service to which the member seeks reappointment.
- (c) Specific requests stating the staff category, service, and clinical privileges for which the member wishes to be considered.
- (d) The name of a peer reference and/or recommendation from a chair who has known the member for at least one year, worked with the member and observed the member's professional performance and who can provide information regarding the member's clinical ability, ethical character, ability to work with others so as not to adversely affect patient care.
- (e) Information regarding whether the: (a) member's license to practice medicine in any jurisdiction or DEA registration has ever been denied, revoked, suspended, restricted, reduced, not renewed, voluntarily or involuntarily relinquished, or if such action is pending, (b) member's Medical Staff membership or privileges at any hospital or health care facility has ever been voluntarily or involuntarily denied, revoked, suspended, restricted, reduced, not renewed, or if such action is pending, (c) member has voluntarily or involuntarily relinquished licensure or Medical Staff membership or privileges at any hospital or health care facility to avoid disciplinary action, (d) member has been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization, or if such action is pending, (e) member has had any judgments or settlements made in professional liability cases or claims, or if there are such cases or claims pending, or (f) member's health status may impair their ability to perform patient care privileges requested or Medical Staff membership responsibilities. If any of items (a) - (f) apply, the details thereof shall be included.
- (f) Documentation that the member carries at least the minimum amount of professional liability insurance coverage as required by the Medical Staff and information on the member's malpractice experience during the past two years, including a consent to release of information by the member's present and past malpractice carriers.



- (g) Information regarding receipt of written notice of any adverse action against the member under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

#### **5.4.3 Verification by the Medical Staff**

The Medical Staff shall expeditiously seek to verify the member's qualifications, including clinical competence, National Practitioner Data Bank status, professional liability status, current licensure, current Drug Enforcement Administration registration, and other information in satisfaction of the basic qualifications for membership in writing and from the primary source whenever feasible. In addition, the Medical Staff shall seek to verify additional qualifications established by the Clinical Service to which the member is applying. The member shall be notified of any problems in obtaining the information required, and it shall be the member's obligation to obtain the required information. When collection and verification is accomplished the application will be forwarded to the appropriate Clinical Service. Practitioner specific performance improvement and patient safety data will accompany the application.

#### **5.4.4 Chief of Service Recommendation**

The Chief of Service shall, upon receiving a completed reappointment application, evaluate the professional performance, judgment, patterns of patient care, and when appropriate, technical skill (through direct observation or consultation with Medical Staff members in good standing who have observed the candidate). The evaluation shall also include the member's practitioner specific performance improvement and patient safety data. Within thirty (30) days of receipt of the completed application, the Chief of Service shall provide the Credentials Committee with a specific written recommendation whether reappointment should be granted, and if so, the clinical privileges for which the applicant is qualified.

#### **5.4.5 Credentials Committee Recommendation**

Within thirty (30) days of receipt of recommendations from the Chief of Service, the Credentials Committee shall determine whether to recommend to the Medical Staff Executive Committee that the member be reappointed or terminated.

#### **5.4.6 Medical Staff Executive Committee Recommendation**

- (a) Action by the Medical Staff Executive Committee shall occur no more than thirty (30) days after the Credentials Committee makes its recommendation. On the recommendation of the Credentials Committee and the Medical Staff Executive Committee, a reappointment decision shall be made by the Governing Body.
- (b) If the Credentials Committee does not receive recommendations from the Clinical Services in which clinical privileges are requested, the Credentials Committee shall make its own recommendation to the Medical Staff Executive Committee on the basis of its own evaluation employing the same type of information usually considered by the Chiefs of Service.

#### **5.4.7 Failure to Timely Complete Reappointment Process**

- [A1](a) Members must submit a complete application for reappointment by the specified due date, allowing adequate time for routine processing prior to expiration of the current term of appointment. If it appears that an application for reappointment will not be fully processed by the expiration date of the member's appointment, for reasons other than due to the practitioner's failure to return documents or otherwise timely cooperate in the reappointment process, a time-limited reappointment may be approved. Any such reappointment shall not create a vested right in continued appointment through the entire two-year term, but only until such time as the processing of the application is concluded. The member shall continue to be subject to the reappointment process described in this Section 5.
- (b) Failure without good cause to timely file a completed application for reappointment shall result in the expiration of the member's practicing privileges and prerogatives at the end of the current staff appointment, at the discretion of the Credentials Committee after giving the member an opportunity to be heard either in writing or at a meeting. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article 8 shall not apply. If the Credentials Committee determines that good cause has been established, a time limited reappointment may be approved. Special terms and conditions, including a focused professional practice evaluation and the payment of a special processing fee, may be imposed.

#### **5.4.8 Failure to Meet Minimum Activity or Proctoring Requirements**

Practitioners who do not meet minimum clinical activity levels established by their Clinical Service under Section 5.3.3 at the time of reappointment may be terminated from the Medical Staff.

- (a) Practitioners terminated from the Medical Staff for not meeting minimum activity requirements as established by each Clinical Service who then supply documentation that they have met the applicable requirement(s) may apply for reinstatement if the information is submitted to the Medical Staff within 30 days of termination.
- (b) Practitioners may submit an application for initial appointment after one year of termination. Such practitioners shall be placed on Provisional status and shall be subject to a focused professional practice evaluation.

#### **Section 5.5 Burden of Producing Information**

In connection with all applications for initial membership, membership renewal, advancement, or transfer, the applicant shall have the burden of producing accurate and adequate information for an evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff Executive Committee which may select the examining physician. Until the Credentials Committee has declared the application complete, the application will be filed as incomplete.

## **Section 5.6 Termination of Appointment and Other Discipline**

**5.6.1** The Medical Staff Executive Committee, on the recommendation of the Credentials Committee, may terminate the appointment of, or otherwise impose discipline on, a member of the Medical Staff during the term of appointment in accordance with Article 7. Prior to the effective date of such termination or other discipline, the Staff member may be entitled to the hearing and appeal procedures set forth in Article 8 depending on the nature and justification for the termination or discipline as described in Section 8.2. Summary suspension may be imposed where the failure to take that action may result in an imminent danger to the health or welfare of any individual as set forth in Section 7.8.

**5.6.2** To the extent the appointment of a Medical Staff member holding an administrative position in the Medical Center is terminated or discipline is otherwise imposed, and such termination or discipline falls within Section 8.2, the member would be entitled to a hearing pursuant to Article 8.

## **Section 5.7 Fees**

### **5.7.1 Initial Application Processing Fee**

All applicants to the Medical Staff shall submit a nonrefundable, initial application processing fee to the Medical Staff. The application fee is subject to change upon approval by the Medical Staff Executive Committee. Non-payment of fees shall result in the applicant's withdrawal of his/her initial application.

### **5.7.2 Reappointment Application Processing Fee**

Members of the Medical Staff shall submit a nonrefundable re-appointment processing fee, at the time of application for reappointment. Non-payment of fees shall result in the member's termination from the Medical Staff.

## **Section 5.8 Authorization and Release**

By applying or reapplying for Medical Staff membership and clinical privileges, the applicant signifies a willingness to appear for interviews and authorizes consultation with others who may have information bearing on the applicant's competence or ethical qualifications. In addition, the applicant, by applying, releases all representatives of The Regents of the University of California, Ronald Reagan UCLA Medical Center, the Medical Staff, and third parties from whom information is requested by an authorized representative of any of the foregoing from any liability in connection with the application and its evaluation, to the fullest extent allowed by law.

## **ARTICLE 6 CLINICAL PRIVILEGES**

### **Section 6.1 Exercise and Delineation of Privileges**

**6.1.1** The Governing Body may grant clinical privileges upon the recommendation of the Medical Staff Executive Committee, the Credentials Committee and Chief(s) of Service in which the practitioner holds appointment. These privileges generally shall be for two years to coincide with the appointment term to the Medical Staff. Privileges for each Medical

Staff member shall be kept on file by Medical Staff Administration and available to the Medical Center by intranet access.

**6.1.2** Medical Staff members shall be entitled to exercise only those clinical privileges specifically granted to the applicant (except as provided in Article 4). Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated competence. Requests may be submitted at the time of initial application, renewal, and revision of clinical privileges. The basis for determination of privileges prior to initial appointment must include observed clinical performance and the documented results of peer review and other performance improvement and patient safety quality of care information from the applicant's residency/fellowship program or accredited healthcare facility. The basis for determination of privileges at reappointment must include observed clinical performance, documented results of peer review, and results of the ongoing professional practice evaluations undertaken by each Clinical Service at Ronald Reagan Medical Center. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources to supplement the required ongoing professional practice evaluations from Ronald Reagan Medical Center.

## **Section 6.2 Temporary Privileges**

**6.2.1** Temporary privileges may be granted by the Governing Body or its designee, at the request and recommendation of the appropriate Chief(s) of Service or Chief of Staff and upon the basis of information available which may reasonably be relied upon as to the competence and ethical standing of the applicant.

**6.2.2** Temporary privileges may be granted for a period of no more than 120 days.

**6.2.3** Temporary privileges shall be granted in the following circumstances:

- (a) Pending appointment to the Medical Staff; or
- (b) For a specific patient or patients, where there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time; or
- (c) To proctor a current medical staff member for a particular procedure for which no other member of the medical staff holds the necessary skills and privileges. In such circumstances the patients will otherwise remain under the care of appropriately privileged medical staff members.

**6.2.4** In the case of Section 6.2.3(a) above, temporary privileges pending appointment shall not be granted unless the applicant has submitted a complete Application for Appointment to the Medical Staff with all of the required accompanying documentation, and the Medical Staff has completed primary source verifications, including current licensure and current competence. The application shall have no current or previous successful challenges to licensure or registration, been subject to involuntary termination of medical staff membership at another institution, nor have been subject to voluntary or involuntary limitation, reduction, denial or loss of clinical privileges. In no circumstances may temporary privileges exceed the period ending with action upon the application for Medical Staff membership.

**6.2.5** In the case of Sections 6.2.3(b) and 6.2.3(c) above, temporary privileges shall not be granted unless the applicant has submitted a complete Application for Temporary Privileges to the Medical Staff with all of the required accompanying documentation, and the Medical Staff has completed primary source verifications, including current licensure and current competence. The application shall have no current or previous successful challenges to licensure or registration, been subject to involuntary termination of medical staff membership at another institution, nor have been subject to voluntary or involuntary limitation, reduction, denial or loss of clinical privileges. In no circumstances may temporary privileges exceed the period requested for the specific patient or circumstance.

Temporary privileges as in the case of Sections 6.2.3(b) and 6.2.3(c) above, will be granted no more than three times in two consecutive years. Any practitioner who submits a request once this limit has been reached will not qualify for temporary privileges and will be invited to submit an application for membership to the Medical Staff.

**6.2.6** Temporary privileges may be terminated with or without cause at any time by the Governing Body or its designee. A practitioner shall be entitled to the procedural rights afforded by Bylaws Article 8, Hearing and Appeal Procedures, only if temporary privileges are denied, terminated, or suspended, as described in Section 8.2. In all other cases (including deferring action upon a request for temporary privileges), the Practitioner shall not be entitled to any procedural or hearing rights based upon any adverse action involving temporary privileges. If the termination or modification is effective immediately, the Chief of Service or designee shall assign a member of the Medical Staff to assume responsibility for the care of any patient whose care would be affected by the termination or modification.

**6.2.7** In the exercise of medical care under the designation of temporary privileges, the Practitioner shall be under the supervision of the appropriate Chief of Service or designee. Special requirements, if any, of supervision and reporting shall be imposed by the Governing Body or its designee, Chief of Staff or appropriate Chief of Service on any person granted temporary privileges.

### **Section 6.3 Special Academic Temporary Privileges**

Temporary privileges may be granted in the manner set forth in these Bylaws to practitioners who are guests of the Medical Center by invitation of the School of Medicine and whose purpose is to engage in professional education through clinical research or demonstrations. In such cases, the following conditions shall apply:

- (a) The Service Chief, under whose auspices the applicant is performing the privileges, shall submit a recommendation regarding the applicant's competency to perform the privileges being requested.
- (b) For out of state practitioners, in accordance with California's Business and Professions Code, Section 2060 of, such practitioners must be licensed in the state or country of their residence.
- (c) In the event the practitioner does not simultaneously hold a visiting appointment at the University of California, Los Angeles, the practitioner shall provide evidence of professional liability insurance in the amount and type required by the Medical Staff.

## **Section 6.4 Temporary Privileges in the Event of a Disaster**

- (a) In the event of a disaster in which the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, the Chief of Staff, or in the absence of the Chief of Staff, the Vice-Chief of Staff, may grant disaster privileges. In the absence of the Chief of Staff and Vice-Chief of Staff, the Chief Executive Officer or his or her designee may grant the disaster privileges consistent with this subsection. The grant of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. An initial grant of disaster privileges must be reviewed by a person authorized to grant disaster privileges within 72 hours of the initial grant to determine whether the disaster privileges should be continued.
- (b) The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control.
  - (1) Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal or regulatory agency and at least one of the following:
    - (i) A current picture hospital ID card clearly identifying professional designation.
    - (ii) A current license to practice.
    - (iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.
    - (iv) Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances.
    - (v) Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.
  - (2) Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate emergency situation is under control, or within 72 hours from the time the volunteer licensed independent practitioner presents himself to the hospital, whichever comes first. If primary source verification cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:
    - (i) The reason[s] verification could not be performed within 72 hours of the practitioner's arrival,
    - (ii) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services.
    - (iii) Evidence of an attempt to perform primary source verification as soon as possible.
- (c) Members of the medical staff shall oversee those granted disaster privileges by direct observation.

## **Section 6.5 Emergency Privileges**

For the purposes of this Section, an “emergency” is defined as a condition in which serious or permanent harm would result to a patient (or other individual) or in which the life of a patient (or other individual) is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any individual who is a member of the Medical Staff or who has been granted clinical privileges at the Medical Center is permitted to do everything possible, within their scope of license, to save a patient's life or to save a patient from serious harm, regardless of the individual's staff status or clinical privileges.

## **Section 6.6 Special Conditions for Dentists**

- 6.6.1** Dentists shall be appointed to the Dentistry Service and assigned an appropriate category of membership at the time of appointment or reappointment after considering the recommendation of the Chief of Dentistry. Their activities in the Medical Center will be under the overall supervision of the Chief of the Surgery Service.
- 6.6.2** Dentists who are members of the Medical Staff may admit patients to the hospital. A physician shall be responsible for the medical care of the patient throughout their hospital stay, including performance and documentation of a complete history and physical examination. The dentist will be responsible for that portion of the history and physical examination applicable to their scope of practice.
- 6.6.3** However, oral and maxillofacial surgeon members of the Medical Staff with appropriate privileges may perform and document the history and physical examination and assess the medical risks of the proposed surgical procedures unless the patient is known to have serious medical problems in which event the patient shall be referred to an appropriate physician.

## **Section 6.7 Special Conditions for Podiatrists**

- 6.7.1** Podiatrists shall be appointed to the Surgery Service and assigned an appropriate category of membership at the time of appointment or reappointment after considering the recommendation of the Chief of the Surgery Service. Their activities will be under the overall supervision of the Surgery Service. A physician shall be responsible for the medical care of the patient, the admission, and the performance and documentation of the history and physical examination of any inpatient. The podiatrist will be responsible for the performance and documentation of that portion of the history and physical examination applicable to their scope of practice.
- 6.7.2** Surgical care to be provided by podiatrists will also be subject to the overall supervision of the Chief of the Surgery Service. A request for surgical clinical privileges by a podiatrist shall be directed to the Chief of the Surgery Service who will make recommendations concerning such requests after appropriate consultation.

## **Section 6.8 Allied Health Practitioners**

- 6.8.1** Allied Health Professionals (“AHPs”) are defined as health care professionals who hold a license or other legal credential, as required by California law, to provide certain patient care services, but are not eligible for Medical Staff membership.

**6.8.2** AHPs who meet the eligibility requirements may be given specified privileges in the Medical Center. Such privileges shall be granted in accordance with the Clinical Service to which the practitioner is assigned and shall be subject to any regulatory supervision requirements.

**6.8.3** The categories of AHPs eligible to apply for privileges at the Medical Center as approved by the Governing Body and who are credentialed by the Medical Staff hereunder include:

Licensed Independent Practitioners: granted Privileges with no direct supervision

- a. Clinical Psychologists
- b. Marriage and Family Therapists
- c. Optometrists

Advanced Practice Professionals: granted Privileges under Supervising Physician

- a. Nurse Anesthetists
- b. Nurse Midwives
- c. Nurse Practitioners
- d. Physician Assistants

**6.8.4** AHPs may or may not be employed by the Medical Center and where employed, shall have a job description specifying their responsibilities. In the case of Advanced Practice Professionals who are working outside their scope of license, the development of Standardized Procedures will be required for submission to the Interdisciplinary Practice Committee for approval. New categories of AHPs may be added based on programmatic need by approval of the Governing Body.

**6.8.5** Although AHPs are not eligible for Medical Staff membership, they may be granted privileges in the Medical Center if: (a) they hold a license, certificate, or other credentials in a category of AHPs that the Governing Body has approved; and (b) they are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws.

**6.8.6 Processing the Application**

Applications shall be submitted and processed in a manner equivalent to that specified for Medical Staff applicants in Article 5, except that the applications shall be submitted to the Interdisciplinary Practice Committee (“IPC”) rather than to the Credentials Committee following review and recommendation by the Clinical Service. The IPC may meet with the applicant and the supervising physician. Whenever possible, the IPC shall include practitioners in the same AHP category when conducting an evaluation. The IPC shall forward its recommendations to the Credentials Committee. Thereafter, the application shall be referred to the Medical Staff Executive Committee and Governing Body.

**6.8.7 Duration of Appointment and Reappointment**

AHPs shall be granted privileges for no more than two years. Reappointment to the AHP staff shall be processed in a manner equivalent to that specified in Article 5, in the Medical Staff Bylaws for Medical Staff members. Applications for renewal of the AHP’s privileges must be completed



by the AHP and submitted for processing in a parallel manner to the reappointment procedures set forth in Article 5 in the Medical Staff Bylaws.

### **6.8.8 General Duties**

Upon appointment, each AHP shall be expected to:

- (a) Be consistent with the privileges granted, exercise judgment within the area of competence and, if applicable, within the limits of an approved standardized procedure, provided that a Medical Staff member (Supervising Physician) who has appropriate privileges shall retain the ultimate responsibility for each patient's care.
- (b) Participate directly in the management of patients to the extent authorized by their license, certificate, other credentials, any applicable standardized procedures, and by the privileges granted by the Governing Body.
- (c) Write orders to the extent established by any applicable Medical Staff or Service policies, rules or standardized procedures and consistent with the privileges granted.
- (d) Record reports and progress notes on patient charts to the extent determined by the appropriate service, and in accordance with any applicable standardized procedures.
- (e) When required, the Supervising Physician shall assure that records are countersigned. Unless otherwise specified in the Rules or specific supervision protocols, all chart entries that require countersignatures must be countersigned within 14 days after the entry is made.
- (f) Consistent with the privileges granted, perform consultations as requested by a Medical Staff member.
- (g) Comply with all Medical Staff Bylaws, Rules, and Regulations and Medical Center policies.

### **6.8.9 Prerogatives and Status**

AHPs are not members of the Medical Staff, and thus shall not be entitled to vote on any Medical Staff or Clinical Service matters.

### **6.8.10 Termination and Suspension of Privileges and Grievance Procedure**

- (a) An AHP's privileges shall automatically terminate in the event:
  - (1) The Medical Staff membership of the Supervising Physician is terminated, whether such termination is voluntary or involuntary;
  - (2) The Supervising Physician informs the Medical Staff that he or she no longer agrees to act as the Supervising Physician for any reason, or the relationship between the AHP and the Supervising Physician is otherwise terminated, regardless of the reason therefore; or
  - (3) The AHP's certification or license expires, is revoked, or is suspended.

- (b) An AHP's privileges may also be terminated or suspended for cause by the Service Chief to which the AHP is assigned or by the Chief of Staff.
- (c) An AHP's privileges shall be automatically suspended during the period that the Medical Staff membership or clinical privileges of the Supervising Physician, if any, are suspended.
- (d) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP to the hearing rights set forth in Article 8. However, AHPs, other than Clinical Psychologists, shall have the right to challenge any action that would constitute grounds for a hearing under Section 8.2 of the Bylaws by filing a written grievance with the Chief of the Clinical Service to which the AHP has been assigned and in which the AHP has privileges, within fifteen (15) days of such action. Upon receipt of such grievance, the Service Chief shall initiate a careful investigation and afford the affected AHP an opportunity for an interview before a Clinical Service committee. The Clinical Service committee shall include, for the purpose of this interview, an AHP or AHPs with privileges at the Medical Center and holding the same or similar license or certificate as the affected AHP. Such AHPs shall be appointed to the committee for this purpose by the Service Chief. The interview shall not be deemed a hearing as described in Article 8, and shall not be conducted according to the procedural rules applicable with respect to hearings. Before the interview, the AHP shall be informed of the general nature of the circumstances giving rise to the proposed action, and at the interview, the AHP may present information relevant thereto. Neither the Clinical Service Chief, the Clinical Service committee, nor the AHP shall be represented at the interview by an attorney. A record of the findings of such interview shall be made. A report of the findings and recommendation shall be made by the Clinical Service Chief to the Medical Staff Executive Committee that shall act thereon. The action of the Medical Staff Executive Committee shall be final, subject to approval by the Governing Body.

#### **6.8.11 Standardized Procedures**

- (a) Definition. "Standardized Procedures" means the written policies and protocols for the performance of Standardized Procedure functions, and which have been developed in accordance with the requirements of California law.
- (b) Functions Requiring Standardized Procedures. Standardized procedures are required whenever any registered nurse (including, but not by way of limitation, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives) practices beyond the scope of license taught in the basic curriculum for registered nurses as contemplated by the California Nurse Practice Act (i.e., whenever special training and/or experience are necessary in order for the nurse to perform the procedure or practice in question).

#### **6.8.12 Development of Standardized Procedures**

- (a) Standardized procedures may be initiated by the appropriate Clinical Service, the affected AHPs, or Supervising Physicians.
- (b) Representatives of the category of AHPs that will be practicing pursuant to the Standardized Procedure shall be involved in developing the standardized procedures. Standardized procedures shall be reviewed by the Clinical Service, and then must be approved by the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Staff Executive Committee, and the Governing Body.

### **Section 7.1 Role of Medical Staff in Performance Improvement and Patient Safety Activities**

The Medical Staff is responsible for overseeing the quality of medical care, treatment and services delivered at Ronald Reagan UCLA Medical Center, and for the quality of care provided by members of the Medical Staff at UCLA-owned and operated non-licensed ambulatory clinics (“Clinics”). For purposes of this Article 7, the Ronald Reagan UCLA Medical Center and the Clinics are referred to collectively as “UCLA Clinical Sites.” The Santa Monica-UCLA Medical Center and the Resnick Neuropsychiatric Hospital are not included in this definition. The following provisions are designed to achieve performance improvement through collegial peer review and educative measures whenever possible, but with recognition that, when circumstance warrant, the Medical Staff is responsible to embark on corrective measures and/or corrective action as necessary to achieve and assure quality of care and patient safety. Toward these ends:

- (a) Members are expected to participate actively and cooperatively in a variety of peer review, performance improvement, and patient safety activities to measure, assess, and improve the performance of their peers in the UCLA Clinical Sites.
- (b) The primary goals of the peer review, performance improvement, and patient safety processes are to prevent, detect and resolve actual and potential problems through routine collegial monitoring, education and counseling; however, when necessary, remedial measures, including formal investigation and discipline, may be implemented and monitored for effectiveness.
- (c) Clinical Service and Medical Staff committees are responsible for carrying out delegated peer review, performance improvement, and patient safety functions in a manner that is consistent, timely, fair and ongoing. However, peer review activities conducted by Clinical Service committees are separate from the activities set forth in this Article 7, unless referral is made by any such committee to the Medical Staff Executive Committee for action under this Article 7.

### **Section 7.2 Preliminary Review of Concern**

Anyone who has any concern regarding the quality or safety of care provided by, or the conduct of, a member of the Medical Staff, may report the concern to the Chief of Staff, Chief Medical Officer, or the applicable Clinical Service Chief. The recipient of the concern or his or her designee, will initiate a preliminary review of the concern and determine whether to recommend Informal Corrective Activities, an Informal Investigation, or Formal Investigation, as described below. The information developed during this preliminary review, and any recommendation, shall be presented at the next regularly scheduled meeting of the Medical Staff Executive Committee, which shall decide whether it agrees with any recommendation and whether further action is appropriate.

### **Section 7.3 Informal Corrective Activities**

The Chief of Staff, Chief Medical Officer, Clinical Service Chiefs, Division Chiefs and Medical Staff committees may counsel, educate, issue letters of admonition, reprimand, warning, or censure, or institute retrospective or concurrent monitoring in the course of carrying out their

duties without initiating an informal or formal investigation. Comments, suggestions, and warnings may be issued orally or in writing. The Medical Staff member shall be given an opportunity to respond in writing and may be given an opportunity to meet with the Chief of Staff, Chief Medical Officer, Clinical Service Chief, Division Chief, or committee. Any letters of admonition, reprimand, warning, or censure, informal actions, monitoring, or counseling shall be documented in writing in the Medical Staff member's peer review file. Medical Staff Executive Committee approval is not required for such actions nor shall such actions constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article 8.

#### **Section 7.4 Informal Investigation**

If the Medical Staff Executive Committee determines that a concern regarding the quality or safety of care provided by, or the conduct of, a member of the Medical Staff requires an investigation to further determine the facts, it may, on its own or through delegation, request additional review and investigation of the matter, and seek an interview with the Medical Staff member at issue. Interviews shall neither constitute nor be deemed a hearing as described in Article 8, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The member shall be informed of the general nature of the concerns that are the basis for the informal investigation. A record of the matters discussed and any findings resulting from the interview shall be made. The Medical Staff Executive Committee may determine that no action, Informal Corrective Activities, or a Formal Investigation is warranted following its conclusion of an Informal Investigation.

#### **Section 7.5 Formal Investigation**

**7.5.1** The Chief of Staff or the Medical Staff Executive Committee may initiate a Formal Investigation when it determines the findings of an Informal Investigation require a formal review, or when reliable information indicates a member may have exhibited acts, demeanor or conduct, either within or outside of the UCLA Clinical Sites, which is reasonably likely to be:

- (a) Detrimental to patient safety or to the delivery of quality patient care within the UCLA Clinical Sites;
- (b) Unethical or unprofessional;
- (c) Contrary to the Medical Staff Bylaws, Rules and Regulations. This shall include, but is not limited to, failure to disclose information pertinent to and necessary for the evaluation of the member's qualifications for appointment or re-appointment to the Medical Staff;
- (d) Care below applicable professional standards. This shall include, but is not limited to, incompetence, negligence, gross negligence, clinical care that is below the standard of practice established by the clinical service, or substantial or consistent misdiagnosis;
- (e) Disruptive behavior at any UCLA Clinical Site. Disruptive behavior shall include, but is not limited to, harassment, discrimination, verbal abuse, the inability to work in harmony with others, patient abandonment, or falsification of records;

- (f) Criminal conviction, including a conviction or plea of guilty or nolo contendere for any felony or for any misdemeanor related to the practice of a health care professional, fraud or abuse relating to any governmental health program, third party reimbursement, or controlled substance, whether or not an appeal has been filed or is pending;
- (g) A material breach of privacy and confidentiality; or
- (h) Significant or adverse impact to the educational or training environment for medical students or trainees.

**7.5.2** If the Chief of Staff, acting on behalf of the Medical Staff Executive Committee, concludes that a Formal Investigation is warranted, he or she shall direct an investigation to be undertaken and the member shall be informed in writing of the investigation and of the allegations that give rise to the investigation. The Chief of Staff may personally conduct the investigation or may assign the task to an appropriate standing or ad hoc committee, or other appropriate individuals or departments or outside experts as retained by the Medical Staff, to be appointed by the Chief of Staff. The investigating body should not include individuals with a conflict of interest, which may include partners, associates or relatives of the individual being investigated. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances. If the investigation is delegated to a committee other than the Medical Staff Executive Committee, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Staff Executive Committee within forty-five (45) days of the assignment. The Chief of Staff may authorize an extension of this time period for good cause. The report may include recommendations for appropriate corrective action. The Medical Staff Executive Committee shall have the discretion to request further investigation and/or clarification of the written report as it deems necessary.

**7.5.3** Following receipt of the final report of the Formal Investigation, the Medical Staff Executive Committee shall notify the affected staff member of the findings and/or concerns, and offer the member an opportunity to make an appearance before the Medical Staff Executive Committee prior to action being taken. Neither this appearance nor the investigation referred to in this 7.5 shall constitute a hearing under Article 8. This appearance shall be, when feasible, at the next regularly scheduled meeting of the Medical Staff Executive Committee unless otherwise directed by the Chief of Staff, shall be preliminary in nature, and none of the procedural rules of the Bylaws with respect to hearings shall apply. Failure by the staff member to appear before the Medical Staff Executive Committee shall not be grounds to delay further determinations and/or action by the Medical Staff Executive Committee. The Medical Staff Executive Committee may also confer with the Chief Medical and Quality Officer for the UCLA Health System, prior to taking any action as set forth in in Section 7.6.

**7.5.4** Despite the status of any investigation(s), at all times the Medical Staff Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action.

## **Section 7.6 Medical Staff Executive Committee Action.**

As soon as practicable after the conclusion of the Formal Investigation and meeting with the member, the Medical Staff Executive Committee shall take action as follows:

### **7.6.1 No Action, Deferred Action, or Informal Corrective Activities:**

- (a) Determining no corrective action be taken and, if the Medical Staff Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- (b) Deferring action for a reasonable time; and/or
- (c) Imposing any of the informal corrective activities described in Section 7.3.

If the Medical Staff Executive Committee determines that no corrective action is required or only a letter of warning or censure should be issued, the decision shall be transmitted to the Governing Body with a copy to the Chief Medical and Quality Officer. The Governing Body may affirm, reject or modify the action. The Governing Body shall give great weight to the Medical Staff Executive Committee's decision and may initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Chief of Staff or his/her designee, and the Medical Staff Executive Committee still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within thirty (30) days after receiving the notice of decision. Unless the corrective action constitutes a "ground for hearing" as that term is defined in Section 8.2, that action shall not entitle the member to a hearing under Article 8.

### **7.6.2 Formal Corrective Actions:**

- (a) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of privileges including, without limitation, requirements for co-admissions, mandatory consultation or monitoring;
- (b) Recommending reduction, modification, suspension or revocation of privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;
- (c) Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- (d) Recommending suspension, revocation or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated; and/or
- (e) Taking other actions deemed appropriate under the circumstances.

If the Medical Staff Executive Committee recommends an action that is grounds for a hearing under Section 8.2, the Chief of Staff shall give the member written notice of the proposed action and of the right to request a hearing consistent with Section 8.3. The Governing Body will be informed of the recommendation with a copy to the Chief Medical and Quality Officer.

## **Section 7.7 Investigatory Leave**

A member of the Medical Staff can be placed on Investigatory Leave in response to an inherently plausible allegation of a violation of UCLA Health policy which could have an adverse effect on the health and safety of patients and/or members of the work force. For example, Investigatory Leave may be appropriate in response to allegations of, among other things, sexual harassment or sexual violence, discrimination, workplace violence, retaliation, disruptive behavior, or impairment. For purposes of this Section 7.7, “inherently plausible” means the facts alleged are reasonable and it is plausible that events occurred in the manner alleged.

- (a) Any two (2) of the following individuals/entities shall have the authority to immediately place a member on Investigatory Leave: the Clinical Service Chief for the service in which the member holds privileges, the Chief Medical Officer, the Chief of Staff (or designee), the Chief Medical and Quality Officer for UCLA Health, and/or the Medical Staff Executive Committee (“MSEC”).
- (b) The Chief of Staff must be concurrently notified of the decision to place the member on Investigatory Leave.

Investigatory Leave is solely intended to remove the member from clinical activity as necessary for the MSEC to obtain additional information regarding the allegations. It is only appropriate where, following consultation with the Chief of Staff or MSEC, there is insufficient information at the time the allegation is received to support a summary suspension or summary restriction of a member’s clinical privileges. Investigatory Leave may be permitted for a period up to 14 days as needed. It may be lifted at any time by the Chief of Staff or by the MSEC if it is determined that continuation of Investigatory Leave is no longer required to obtain additional information regarding the allegations. There is no obligation for the investigation of the allegations to be completed during the investigatory leave period. If it is determined at any point during the investigatory leave period that the member poses an imminent danger to the health or safety of a patient, prospective patient, employee, member of the Medical Staff, or other person present in the UCLA Clinical Sites, or to the operations of the UCLA Clinical Sites, the investigatory leave shall immediately be cancelled and the member’s clinical privileges summarily restricted or suspended consistent with Section 7.8 of the Medical Staff Bylaws.

**7.7.1** Unless otherwise expressly stated, the Investigatory Leave under this section shall apply to the member’s clinical activities across and throughout all the UCLA Clinical Sites, and to his/her memberships in the UCLA Medical Group, the Medical Staff of Santa Monica-UCLA Medical Center, and/or the Professional Staff of the Resnick Neuropsychiatric Hospital at UCLA, as applicable.

Placement of a member on Investigatory Leave shall not be deemed a restriction, suspension, or termination of clinical privileges based on professional competence or conduct which affects or could adversely affect the health or welfare of a patient or patients, and therefore shall not entitle a member to a hearing under Article 8 of the Medical Staff Bylaws. Patients will be reassigned to other clinical providers, as necessary, while the member is on Investigatory Leave.

As may be required by law or policy, all allegations that are the basis for Investigatory Leave shall be reported to any appropriate office within the University, including but not limited to, the Office of Title IX, the Office of Staff Diversity, Discrimination and Prevention Office, Emergency Preparedness, Safety and Security Services, the Medical Staff Health Committee, and/or local law

enforcement. Nothing in this Section 7.7 shall be interpreted to supersede or substitute the authority of those University offices, and the MSEC shall, during its investigation of any allegation that serves as the basis for Investigatory Leave, consult and/or coordinate with these University offices, as may be appropriate pursuant to University policy.

## **Section 7.8 Summary Restriction or Suspension**

### **7.8.1 Initiation of Summary Restriction or Suspension**

- (a) Notwithstanding anything to the contrary herein, a member's clinical privileges may be summarily suspended or restricted where the failure to take such action may result in an imminent danger to the health or safety of any patient, prospective patient, employee, member of the Medical Staff, or other person present in the UCLA Clinical Sites, or to the operations of the UCLA Clinical Sites. Any two (2) of the following individuals/entities shall have the authority to summarily suspend a member's privileges: the Clinical Service Chief in which the member holds privileges, the Chief Medical Officer, the Chief of Staff (or designee), the Chief Medical and Quality Officer for UCLA Health, and/or the Medical Staff Executive Committee.
- (b) The Chief of Staff must be concurrently notified of the decision to summarily suspend the member.

### **7.8.2 Duration of Summary Restriction or Suspension**

- (a) The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until ratified by the Medical Staff Executive Committee as set forth in this Section 7.8.3.
  - (1) Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall immediately give written notice to the Governing Body, the Medical Staff Executive Committee, the Clinical Service Chief, the Chief Medical and Quality Officer, and the President of UCLA Health. The notice shall generally describe the reasons for the action.
  - (2) Within three (3) working days of imposition of a summary suspension or restriction, the member shall be provided with written notice of such action. This initial notice shall include a statement of facts explaining why the summary action was warranted. The written notice shall inform the member: (a) of the right to an informal interview upon request; (b) that if a summary suspension or restriction remains in effect for more than fourteen (14) days, the action will be reported to the Medical Board of California pursuant to California Business and Professions Code Section 805; and (c) that the suspension could be reportable to the National Practitioner Data Bank if it remains in effect for more than 30 days.
- (b) Unless otherwise indicated by the terms of the summary action, the member's patients shall be promptly assigned to another member of the service, by the Chief of Staff, Service Chief, or Division Chief considering, where feasible, the wishes of the patient and the affected member in the choice of a substitute member.



### **7.8.3 Medical Staff Executive Committee Action**

Within seven (7) working days after any summary restriction or suspension has been imposed, a meeting of the Medical Staff Executive Committee shall be convened to review and consider the action. Upon request, the affected member may attend and request an interview with the Medical Staff Executive Committee. The interview shall be convened as soon as reasonably practicable, shall be informal, and shall not constitute a hearing under Article 8. The Medical Staff Executive Committee may thereafter continue, modify, or terminate the terms of the summary action. It shall give the member written notice of its decision within three (3) working days of its meeting. Said notice shall include the information specified in Section 7.8.2 if the action is adverse to the member. Unless the Medical Staff Executive Committee terminates the summary action, it shall remain in effect during the pendency and completion of the corrective action process and/or of the hearing and appellate review process set forth in Article 8, if applicable.

### **7.8.4 Scope of Summary Restriction or Suspension**

Unless otherwise expressly stated, the summary restriction or suspension of a member's clinical privileges under this Section shall apply to the member's clinical activities across and throughout the UCLA Clinical Sites and to his or her memberships in the UCLA Medical Group, the Medical Staff of Santa Monica-UCLA Medical Center, and/or the Professional Staff of the Resnick Neuropsychiatric Hospital at UCLA, as applicable.

## **Section 7.9 Automatic Suspension or Limitation**

In the following instances, the member's privileges or membership may be suspended or limited automatically as follows and such suspensions or limitations shall be recorded by the Medical Staff:

### **7.9.1 Licensure**

- (a) **Revocation, Suspension or Expiration:** Whenever a member's license or other legal credential, certificate or permit authorizing practice in this state is revoked, suspended or expired, Medical Staff membership and privileges shall be automatically subjected to the same action as of the date such action becomes effective. If, after 180 consecutive days of suspension the member remains suspended under this provision, the member shall be automatically terminated from the Medical Staff.
- (b) **Restriction:** Whenever a member's license, other legal credential authorizing practice in this state, certificate or permit issued to permit specific privileges following routine testing is limited or restricted by the applicable licensing or certifying authority or by the Medical Center, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- (c) **Probation:** Whenever a member is placed on probation by the applicable licensing or certifying authority his or her membership status and privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

## **7.9.2 Drug Enforcement Administration (DEA) Registration**

- (a) Revocation, Limitation, Suspension and Expiration: Whenever a member's DEA registration is revoked, limited, suspended, or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the DEA registration as of the date such action becomes effective and throughout its term.
- (b) Probation: Whenever a member's DEA registration is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

## **7.9.3 Medical Records**

Medical Staff members are required to complete medical records within the time prescribed in the Bylaws, Rules and Regulations. Failure to complete medical records in a timely manner, absent sufficient justification as determined by the Chief of Staff in his or her sole discretion, shall result in an automatic suspension after notice is given as provided in the Rules. Such suspension shall apply to the member's right to admit, treat, or provide services to new patients in the Medical Center, but shall not affect the right to continue to care for a patient the member has already admitted or is treating. The suspension shall continue until the medical records are completed. If, after 180 consecutive days, the member remains suspended, the member shall be automatically terminated from the Medical Staff.

## **7.9.4 Cancellation of Professional Liability Insurance**

Failure to maintain professional liability insurance as required by the University of California and by these Bylaws shall be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A failure to provide evidence of appropriate coverage after 180 days of suspension shall be automatically terminated from the Medical Staff.

## **7.9.5 Failure to Pay Fees/Fines**

Failure, without good cause as determined by the Medical Staff Executive Committee, to pay fees/fines shall be grounds for automatic suspension of a member's clinical privileges, and if within six months after written warnings of the delinquency the member does not pay the required fees/fines, the member's membership shall be automatically terminated.

## **7.9.6 Other Regulatory or Mandated Training Requirements**

- (a) Failure to provide evidence of the current status of Tuberculin Testing (Ref IC 004 Tuberculosis Exposure Control Plan) at the time of initial appointment and/or reappointment shall be grounds for automatic suspension of a member's privileges. The suspension shall be effective until notification of clearance is received from the Medical Center's Occupational Health Facility. A failure to provide evidence

of clearance after 180 days of suspension shall result in automatic termination from the Medical Staff.

- (b) Failure to provide evidence of completion of the UCLA Health Insurance Portability and Accountability Act (“HIPAA”) Privacy & Security Workforce Training at the time of initial appointment and/or reappointment shall be grounds for automatic suspension of a member’s privileges. The suspension shall be effective until notification of completion is received. A failure to provide evidence of completion after 180 days of suspension shall result in automatic termination from the Medical Staff.
- (c) Failure to provide evidence of completion of an approved boundaries training program at the time of initial appointment and/or reappointment shall be grounds for automatic suspension of a member’s privileges. The suspension shall be effective until notification of completion is received. A failure to provide evidence of completion after 180 days of suspension shall result in automatic termination from the Medical Staff.

### **7.9.7 Exclusion from Government Programs**

Whenever a member is excluded from a Federal or State health care program in accordance with applicable federal or state laws and regulations, the member’s Medical Staff membership and clinical privileges shall be terminated automatically as of the date the exclusion becomes effective. Federal and State health care programs shall include, but are not limited to, Medicare, Medi-Cal, TriCare (formerly CHAMPUS), California Children’s Services, Maternal and Child Health Services, and Block Grants to the State Children’s Health Insurance Program.

### **7.9.8 Felony Conviction**

A member who has been convicted of a felony or who pleads *nolo contendere* to a felony may be suspended automatically by the Medical Staff Executive Committee if the Committee concludes that the felony conviction has a relationship to the qualifications, functions, or duties of Medical Staff membership. Such suspension shall become effective immediately upon such conviction regardless of whether or not an appeal is taken or pending from said judgment. Such suspension shall remain in effect until the matter is resolved by the courts.

### **7.9.9 Automatic Termination**

If a member is suspended for more than six months for any reason set forth above in Section 7.9.1 through 7.9.7, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require a new application and compliance with the appointment procedures applicable to applicants.

### **7.9.10 Medical Staff Executive Committee Deliberation and Procedural Rights**

As soon as practicable after action is taken or warranted as described elsewhere in this Article, with the exception of routine suspensions for failure to complete medical records, the Medical Staff Executive Committee shall review and consider the facts, and may take or recommend such additional action as it deems appropriate.

There shall be no hearing rights under Article 8 for actions automatically affecting a member's Medical Staff status or clinical privileges. However, the member may be given an opportunity to be heard by the Medical Staff Executive Committee related solely to the question whether grounds exist for the special action as described above; the Medical Staff Executive Committee shall reverse any action that was based on a material mistake of fact as to the existence of the grounds for such special action. Additional actions taken by the Medical Staff Executive Committee on a discretionary basis shall be subject to hearing rights to the extent provided for under Article 8.

#### **7.9.11 Notice of Automatic Suspension or Limitation**

Notice of an automatic suspension or action for reasons other than delinquent medical records, failure to maintain professional liability insurance, and/or other regulatory requirements, shall be given to the affected individual, and notice of the suspension shall be given to the Service, the President of UCLA Health, and the Governing Body, with a copy to the Chief Medical and Quality Officer, but such notice shall not be required for the suspension to become effective. Patients affected by such automatic suspension shall be assigned to another member by the Service or Division Chief. The wishes of the patient and affected member shall be considered, where feasible, in choosing a substitute member.

#### **7.9.12 Scope of Automatic Suspension or Action**

Unless otherwise expressly stated, any automatic suspension or limitation of a member's clinical privileges under this Section shall apply to the member's clinical activities across and throughout the UCLA Clinical Sites and to his or her memberships in the UCLA Medical Group, the Medical Staff of Santa Monica-UCLA Medical Center, and/or the Professional Staff of the Resnick Neuropsychiatric Hospital at UCLA, as applicable.

#### **7.9.13 Joint Evaluation and Corrective Action Among University of California Peer Review Bodies**

- (a) Each peer review body within the UCLA Health System, including the Medical Staffs of the Ronald Reagan UCLA Medical Center, the Santa Monica-UCLA Medical Center, the Professional Staff of Resnick Neuropsychiatric Hospital, the UCLA Medical Group, the ambulatory clinics, and the Academic Departments of the David Geffen School of Medicine at UCLA, shall have the authority and discretion to share peer review information and documents and collaborate with any or all of the other peer review bodies in the evaluation and/or investigation of practitioners and the consideration of corrective actions.
- (b) All information that is exchanged pursuant to these provisions shall be maintained in confidence as a peer review record subject to the discovery protections of Section 1157 of California's Evidence Code.

#### **Section 7.10 Failure to Respond or Appear**

Members have an obligation to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly, fully, and appropriately to correspondence, and appearing at appropriately announced meetings regarding quality of care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs, including investigations by the Medical Staff into a member's professional competence or conduct. It also includes submitting to

mental or physical examinations, as requested by the Chief of Staff, the Clinical Service Chief, or the Medical Staff Executive Committee, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's privileges or related issues of reasonable accommodation.

Failure to comply with this Section shall constitute grounds for the Chief of Staff or a Service Chief to suspend the member's clinical privileges and/or take any other appropriate action until a response is provided which is satisfactory to the requesting party. Any such suspension or action imposed thereto shall remain in effect until the member is expressly notified that it is rescinded.

## **ARTICLE 8 HEARINGS AND APPEAL PROCEDURES**

### **Section 8.1 General Provisions**

#### **8.1.1 Intent**

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

#### **8.1.2 Exhaustion of Remedies**

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

#### **8.1.3 Intra-Organizational Remedies**

The hearing and appeal rights established in these Bylaws are strictly "judicial" rather than "legislative" in structure and function. The hearing bodies described in Section 8.5 have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules or Policies. However, the Governing Body may, at its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules, or Policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule, or Policy is lawful or meritorious, the Practitioner is not entitled to a hearing or appellate review. In such cases, the Practitioner must submit his challenges first to the Governing Body. The Governing Body shall consult with the Medical Staff Executive Committee before taking final action regarding the Bylaw, Rule, or Policy involved.

#### **8.1.4 Definitions**

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

- (a) “Body whose decision prompted the hearing” refers to the Medical Staff Executive Committee in all cases where the Medical Staff Executive Committee or authorized Medical Staff officers, members or committees took action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.
- (b) “Practitioner,” as used in the Article, refers to the physician who may request or has requested a hearing pursuant to this Article.

### **8.1.5 Substantial Compliance**

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

### **Section 8.2 Grounds for Hearing**

Any one of the following adverse actions or recommended actions shall be deemed grounds for a hearing:

- (a) Denial or rejection of an application for Medical Staff membership or clinical privileges based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;
- (b) Revocation or termination of Medical Staff membership or clinical privileges based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;
- (c) Restriction of Medical Staff membership or clinical privileges (except for proctoring incidental to Provisional Status, new privileges, insufficient activity, or return from leave of absence) for a cumulative total of thirty (30) days or more for any consecutive 12-month period based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients; or
- (d) Any other disciplinary action or recommendation that must be reported, by law, to the Medical Board of California.

No actions or recommendations except those described above shall entitle the Practitioner to request a hearing under this Article.

### **Section 8.3 Notice of Action or Recommendation**

In all cases in which action has been taken or recommended as set forth in Section 8.2, the Practitioner shall be given written notice of the action or recommendation, including the following information:

- (a) A description of the action or recommendation;

- (b) A brief statement of the reasons for the action or recommendation;
- (c) A statement that the Practitioner may request a hearing;
- (d) A statement of the time limit within which a hearing may be requested;
- (e) A summary of the Practitioner's rights at a hearing; and
- (f) A statement as to whether the action or recommendation must be reported to the Medical Board of California and/or the National Practitioner Data Bank.

#### **Section 8.4 Request for Hearing**

- (a) The Practitioner shall have thirty (30) days following receipt of the notice of action or recommendation within which to request a hearing. The request shall be in writing and addressed to the Chief of Staff, and received by Medical Staff Administration within the deadline.
- (b) If the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Said action shall thereupon become the final action of the Medical Staff. The action or recommendation shall be presented for consideration by the Governing Body, which shall not be bound by it. If the Governing Body ratifies the action or recommendation, it shall thereupon become the final action of the Medical Center. However, if the Governing Body, after consulting with the Chief of Staff, is inclined to take action against the Practitioner that is more adverse than the action recommended by the Medical Staff, the Practitioner shall be so notified and given an opportunity for a hearing as provided herein.
- (c) If the hearing is based upon an adverse action by the Governing Body, it shall delegate an individual to fulfill the functions assigned in this Article to the Chief of Staff. The procedure may be modified as warranted under the circumstances, but the Practitioner shall have the same rights to a fair hearing.

#### **Section 8.5 Hearing Procedure**

##### **8.5.1 Time and Place for Hearing**

Upon receipt of a request for a hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) days from the date he or she received the request for a hearing, give written notice to the Practitioner of the time, place, and date of the hearing. The date of commencement of the hearing shall be not less than thirty (30) days or more than ninety (90) days from the date of the notice, except as approved by the Arbitrator (or Hearing Officer) for good cause. In no event, however, will the hearing be postponed or continued more than sixty (60) days beyond the timeframe set forth in this Section 8.5.1. This notice shall also provide whether the hearing will take place before an Arbitrator or Hearing Committee.

## **8.5.2 Notice of Reasons/Charges**

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

## **8.5.3 Arbitrator**

- (a) When a hearing is requested, the Chief of Staff shall appoint an Arbitrator to preside at the hearing. The Arbitrator shall be an attorney at law, qualified to preside over a medical staff peer review hearing. The Arbitrator shall not be biased for or against any party and shall gain no direct financial benefit from the outcome of the proceedings. Except as otherwise stipulated by the parties, an attorney who regularly represents the Medical Center, Medical Staff, or the Practitioner shall not be eligible to serve as the Arbitrator.
- (b) Unless the parties stipulate otherwise, the parties shall be afforded a reasonable opportunity to participate in the selection of the Arbitrator as follows:
  - (1) Within seven (7) days of providing the Notice of Time, Place, and Date of the Hearing, the Chief of Staff shall provide the Practitioner with a list of up to three (3) potential Arbitrators;
  - (2) Practitioner shall respond within five (5) calendar days with either an acceptance of any of the proposed Arbitrators or with a list of up to three (3) other potential Arbitrators; and
  - (3) If the parties are unable to reach an agreement on the selection of the Arbitrator within five (5) calendar days of receipt of the Practitioner's proposed list, the Chief of Staff shall select an individual from the composite list.
- (c) The Arbitrator must not act as a prosecuting officer or as an advocate. The Arbitrator shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Arbitrator shall be entitled to determine the order of or the procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence that are raised prior to, during, or after the hearing. If the Arbitrator determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the Arbitrator may take such action as he or she deems warranted by the circumstances.
- (d) The Arbitrator shall have such powers and authorities as are necessary to discharge his, her, or its responsibilities, including that the Arbitrator shall have the authority to implement procedures and processes reasonable under the applicable



circumstances to ensure a fair and efficient hearing process consistent with this Article.

- (e) Consistent with the intent of these hearing procedures to provide for a fair review of decisions that adversely affect Practitioners and at the same time establishing a hearing process which provides for the efficient and least burdensome level of formality in the process, the Arbitrator shall have the discretion to impose reasonable time limits or restrictions on the presentation of evidence, testimony, and/or arguments by the parties at the hearing (*e.g.*, up to six hours for a party to present their case). Any time limitations or restrictions imposed on a party shall apply equally to all parties at the hearing, absent a showing of good cause.
- (f) Regardless of the use of the term “Arbitrator,” the hearing proceedings set forth in this Article do not constitute formal arbitration proceedings and are not subject to any external arbitration rules (*e.g.*, American Arbitration Association rules). The hearing proceedings shall only be conducted as set forth in these Bylaws.

#### **8.5.4 Hearing Committee**

- (a) Alternatively, the Chief of Staff has the sole discretion to forego a hearing before an Arbitrator and instead arrange for the hearing to be held before a Hearing Committee. Failure or refusal to exercise this discretion shall not constitute a breach of the Medical Staff’s responsibility to provide a fair hearing.
- (b) Should the Chief of Staff elect to appoint a Hearing Committee, the Hearing Committee shall be composed of not less than three (3) members of the Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders or initial decision-makers, and otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee. If the Chief of Staff determines, as a matter of discretion, that it is in the best interests of the hearing process to go beyond the Medical Staff of this facility for the appointment of Hearing Committee members, he or she may draw from other Medical Staffs within the UCLA Health System. The Chief of Staff shall designate the chair of the Hearing Committee.
- (c) If a Hearing Committee is used, a majority of the committee members must be present throughout the hearing. If a Hearing Committee member will be unable to attend a hearing session for any reason, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The Hearing Officer, described below, shall have the discretion to allow a member of the Hearing Committee to participate through appropriate video mechanisms.
- (d) If a Hearing Committee is used, the Chief of Staff shall select a Hearing Officer to preside at the hearing. The Hearing Officer shall meet the same criteria and qualifications as the Arbitrator as set forth in Section 8.5.3. In addition, the Hearing Officer may participate in the deliberations of the Hearing Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

### **8.5.5 Voir Dire Examination**

- (a) The parties shall have the right to request a reasonable opportunity to conduct a *voir dire* examination of the Arbitrator, the members of the Hearing Committee, and/or the Hearing Officer, as applicable, regarding the criteria and qualifications set forth herein. Peremptory challenges (*i.e.*, challenges without stating a reason) are not permitted. This examination shall take place at least seven (7) days prior to the scheduled hearing date.
- (b) The examination shall be limited as to time and scope so as to provide for the least burdensome level of formality in the process and yet still provide for a fair examination. The Arbitrator (or Hearing Officer if a Hearing Committee is used), shall establish the procedure by which the right of *voir dire* may be exercised, which may include requirements that: (i) *voir dire* questions be proposed in writing at least five (5) days in advance of the examination; (ii) limiting the examination by each party to 20 minutes, with additional time being permitted only upon a showing of good cause; and/or (iii) providing for the *voir dire* examination to be conducted by telephone conference call rather than in person.
- (c) Challenges to the *voir dire* procedure or the impartiality of the Arbitrator, the Hearing Committee, or the Hearing Officer, as applicable, shall be ruled on by the Arbitrator (or the Hearing Officer).

### **8.5.6 Representation**

The Practitioner shall have the right, at his or her expense, to attorney representation at the hearing. If the Practitioner elects to have attorney representation, the Medical Staff Executive Committee may also have attorney representation. Conversely, if the Practitioner elects not to be represented by an attorney at the hearing, then the Medical Staff Executive Committee shall not be represented by an attorney at the hearing. Representation in any appeal is discussed separately in Section 8.9.7.

### **8.5.7 Failure to Appear or Proceed; Non-Cooperation or Disruption**

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

## **Section 8.6 Discovery**

### **8.6.1 Rights of Inspection and Copying.**

The Practitioner may request to inspect and copy, at his or her expense, any documentary information relevant to the charges that the Medical Staff Executive Committee has in its possession or under its control. The Medical Staff Executive Committee may request to inspect and copy, at its expense, any documentary information relevant to the charges that the Practitioner has in his or her possession or under his or her control. Requests for discovery shall be met as soon as practicable, but shall in no event be longer than 30 days from the date the party received the request, subject to reasonable extensions by agreement of the parties. Repeated failure to provide relevant information in a timely manner may result in the termination of proceedings against that party as set forth in Section 8.5.7.

### **8.6.2 Limits on Discovery**

The Arbitrator (or Hearing Officer) shall rule on discovery disputes that the parties cannot resolve. Discovery may be denied or safeguards may be imposed when justified to protect peer review or in the interest promoting a fair and efficient hearing process. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the Practitioner under review, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information. Finally, discovery should be limited to matters that are directly relevant to the charges set forth in the Notice of Charges or Reasons.

### **8.6.3 Ruling on Discovery Disputes**

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

- (a) Whether the information sought may be introduced to support or to defend against the charges;
- (b) Whether the information is “exculpatory” in that it would dispute or cast doubt upon the charges or “inculpatory” in that it would prove or help support the charges and/or recommendation;
- (c) The burden imposed on the party in possession of the information sought, if access is granted; and
- (d) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

## **Section 8.7 Pre-Hearing**

### **8.7.1 Pre-hearing Document Exchange**

The parties shall exchange all documents that will be introduced at the hearing. The documents must be exchanged at least fifteen (15) days prior to the hearing. Each party shall be responsible for removing or redacting any confidential or protected patient information from any documents

before they are exchanged. Failure to comply with this Section shall constitute good cause for the Arbitrator (or Hearing Officer) to limit or disallow the introduction or use of any documents not timely provided to the other party.

### **8.7.2 Exchange of Witness Lists**

Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence on behalf of that party at the hearing. Failure to comply with this rule shall constitute good cause for the Arbitrator (or Hearing Officer) to limit or disallow the testimony of any undisclosed or untimely disclosed witnesses at the hearing. Nothing in the foregoing, however, shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses.

### **8.7.3 Objections to Introduction of Evidence Previously Not Produced for the Medical Staff**

The Medical Staff Executive Committee may object to the introduction of evidence that was not provided during an appointment, reappointment, or privilege application review, or during a formal investigation or corrective action process under Section 7.5, despite the requests of the peer review body for such evidence. The evidence may be excluded from the hearing by the Arbitrator (or Hearing Officer) unless the Practitioner can establish that he or she previously acted diligently and/or reasonably could not have submitted the evidence when it was requested during the application review or investigation process.

### **8.7.4 Expert Witnesses**

Subject to the Arbitrator's (or Hearing Officer's) determination of relevance, including a consideration of the applicable burden of proof as set forth in Section 8.8.5, no expert testimony by individuals not members of the Medical Staff shall be permitted unless the following information is exchanged in written form no less than thirty (30) days before the date of the hearing:

- (a) A curriculum vitae setting forth the qualifications of the expert.
- (b) A complete expert witness report, which must include the following:
  - (1) A complete statement of all opinions the expert will express and the bases and reasons for each opinion.
  - (2) The facts or data considered by the expert in forming the opinions.
  - (3) Any exhibits that will be used to summarize or support the opinions.
  - (4) A representation that the expert has agreed to testify at the hearing.

### **8.7.5 Pre-Hearing Conference**

The parties shall participate in a pre-hearing conference with the Arbitrator (or Hearing Officer) no later than seven (7) days prior to the scheduled hearing date for purposes of narrowing the issues

to be decided and streamlining the hearing process. The pre-hearing conference may be conducted telephonically, remotely, or in-person.

The parties shall be entitled to file motions or otherwise request rulings as necessary in order to give full effect to rights established by the Bylaws and to resolve any procedural or evidentiary issues that may properly be resolved prior to the hearing. Pre-hearing motions must be submitted to the Arbitrator (or Hearing Officer) and served on the opposing party at least five (5) days prior to the pre-hearing conference date, absent good cause. The Arbitrator (or Hearing Officer) shall have the authority to limit and otherwise regulate the submission of such motions or requests, as a matter of discretion, upon a determination that the process is being abused by frivolous or excessive filings or is causing delays without reasonable corresponding benefits to the hearing process.

## **Section 8.8 Hearing**

### **8.8.1 Record of Hearing**

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

### **8.8.2 Attendance**

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Arbitrator (or Hearing Officer), the following shall be permitted to attend the entire hearing in addition to the Arbitrator (or, if used, the Hearing Committee and Hearing Officer), the court reporter, and the parties (with attorneys, if any, subject to Section 8.5.6): the Director of Medical Staff Administration, and the Chief Medical Officer or his or her designee. Such individuals shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that he or she will be a witness for one of the parties.

### **8.8.3 Rights of the Participants**

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

### **8.8.4 Rules of Evidence**

Judicial rules of evidence and procedure relating to the conduct of a trial, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these provisions.

## **8.8.5 Burdens of Presenting Evidence and Proof**

### **(a) Burden of Presenting Evidence**

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

### **(b) Burden of Proof for Corrective Actions or Recommendations**

The body whose decision prompted the hearing shall bear the burden of persuading the Arbitrator (or Hearing Committee), by a preponderance of the evidence, that its action or recommendation was reasonable and warranted based upon the evidence it considered and/or could have considered at the time of its action or recommendation. The term “reasonable and warranted” means within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing at the time of the relevant decision(s), as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Arbitrator (or Hearing Committee).

### **(c) Burden of Proof for Denial of Membership and/or Privileges**

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

## **8.8.6 Adjournment and Conclusion**

The Arbitrator (or Hearing Officer) may adjourn and reconvene the hearing at such times and intervals as may be reasonable and warranted, with due regard for the objective of reaching an expeditious conclusion to the hearing. Both the Medical Staff Executive Committee and the Practitioner may submit a written statement at the end of the evidentiary presentations. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

## **8.8.7 Basis for Decision**

The decision of the Arbitrator (or Hearing Committee) shall be based solely on the evidence introduced at the hearing.

## **8.8.8 Decision of the Arbitrator or Hearing Committee**

Within thirty (30) days after the close of the hearing, the Arbitrator (or Hearing Committee) shall render a written decision. A copy of the decision shall be forwarded to the Chief of Staff, the  
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Governing Body, and the Practitioner. The report shall contain the Arbitrator's (or Hearing Committee's) findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The decision shall include a written explanation of the procedure for appealing the decision. The decision shall be considered final, subject only to such rights of appeal or review as described in these Bylaws.

## **Section 8.9 Appeal**

### **8.9.1 Time for Appeal**

Within ten (10) days after receipt of a decision under Section 8.8.8, either the Practitioner or the Medical Staff Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief Medical Officer and the other party in the hearing. If a request for appellate review is not received within the time and in the manner specified, the decision of the Arbitrator (or Hearing Committee) shall thereupon become final, except if modified or reversed by the Governing Body.

### **8.9.2 Burden of Producing Hearing Record**

It shall be the obligation of the party requesting appellate review to produce the record of the proceedings. If the record is not produced within a reasonable period, as determined by the Governing Body or its authorized representative, appellate rights shall be deemed waived and the decision of the Arbitrator (or Hearing Committee) shall thereupon become final.

### **8.9.3 Waiver of Appellate Rights**

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

### **8.9.4 Grounds for Appeal**

A written request for an appeal shall include an identification of the grounds of appeal, and a clear and concise statement of the facts in support of the appeal. The recognized grounds for appeal from an Arbitrator's (or Hearing Committee's) decision are limited to:

- (a) Substantial non-compliance with the standards or procedures required by these Bylaws which has created demonstrable prejudice to the party; and

- (b) The factual findings of the Arbitrator (or Hearing Committee) are not supported by substantial evidence based upon the hearing record or such additional evidence as may be permitted pursuant to Section 8.9.7 below.

### **8.9.5 Appeal Board**

The Governing Body may sit as the Appeal Board, or it may delegate that function to an Appeal Board which shall be composed of not less than three (3) individuals designated by the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board so long as that person did not take part in a prior hearing on the action or recommendation being challenged. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

### **8.9.6 Time, Place and Notice**

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

### **8.9.7 Appeal Procedure**

The proceedings by the Appeal Board shall be in the nature of an appellate review based upon the record of the proceedings before the Arbitrator (or Hearing Committee). The Appeal Board shall also have the discretion to remand the matter back to the Arbitrator (or Hearing Committee) for the taking of further evidence or for clarification or reconsideration of the Arbitrator's (or Hearing Committee's) decision. In such instances, the Arbitrator (or Hearing Committee) shall report back to the Appeal Board within such reasonable time limits as the Appeal Board imposes. Each party shall have the right to be represented by legal counsel before the Appeal Board, to present a written argument to the Appeal Board, and to personally appear and make oral argument and respond to questions in accordance with the procedure established by the Appeal Board. After the arguments have been submitted, the Appeal Board shall conduct its deliberations outside the presence of the parties and their representatives.

### **8.9.8 Decision**

Within thirty (30) days after the final adjournment of the appeal proceeding, the Appeal Board shall render a decision in writing and shall forward copies thereof to each side involved in the hearing. Final adjournment shall be when the Appeal Board has concluded its deliberations. The Appeal Board may affirm, reverse, or modify the decision of the Arbitrator (or Hearing Committee), and its decision shall constitute the final decision of the Medical Center. Any recommendation affirmed by the Appeal Board shall become effective immediately.

## **Section 8.10 Right to One Hearing**

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



## **Section 8.11 Exceptions to Hearing Rights**

### **8.11.1 Exclusive Contracts**

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

### **8.11.2 Allied Health Professionals**

Allied Health Professionals are not entitled to the hearing rights set forth in this Article except as required by law.

### **8.11.3 Failure to Meet the Minimum Qualifications**

Practitioners shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications, or requests are denied because of their failure to have a current California license to practice medicine, dentistry clinical psychology or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws or the rules); to maintain professional liability insurance; or to meet any of the other basic standards or regulatory requirements or to render an application complete as specified in these Bylaws.

### **8.11.4 Failure to Meet Minimum Activity Requirements**

Practitioners shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted, or terminated or their medical staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws. In such cases, the only review shall be provided by the Medical Staff Executive Committee through a subcommittee consisting of at least three Medical Staff Executive Committee members. The subcommittee shall give the member notice of the reasons for the intended denial or change in membership, privileges, and/or category and shall schedule an interview with the subcommittee to occur no less than 30 days and no more than 100 days after the date the notice was given. At this interview, the member may present evidence concerning the reasons for the action, and thereafter the subcommittee shall render a written decision within 45 days after the interview. A copy of the decision shall be sent to the member, the Medical Staff Executive Committee and the Governing Body. The subcommittee decision shall be final unless it is reversed or modified by the Medical Staff Executive Committee within 45 days after the decision was rendered, or the Governing Body within 90 days after the decision was rendered.

### **8.11.5 Denial of Termination of Temporary Privileges**

No Practitioner shall be entitled to a hearing or appeal if temporary privileges are denied or terminated or otherwise restricted, unless such action or recommendation would require the filing of a report pursuant to Section 805 of the California Business & Professions Code.

## **Section 8.12 Joint Hearings and Appeals**

### **8.12.1 Joint Hearings**

- (a) Whenever a Practitioner is entitled to a hearing under this Article because a credentialing or corrective action has been taken or recommended as a result of a Practitioner's conduct or activities that involves more than one peer review body within the UCLA Health System, including the Medical Staffs of the Ronald Reagan UCLA Medical Center, the Santa Monica-UCLA Medical Center, the Professional Staff of the Resnick Neuropsychiatric Hospital, and/or the Academic Departments of the David Geffen School of Medicine at UCLA, a single joint hearing may be conducted in accordance with these hearing procedures, provided:
  - (i) each participating Medical Staff has adopted the same or similar provisions; and
  - (ii) each Chief of Staff has elected to participate in the joint hearing, as a matter of discretion.
  
- (b) Joint hearings may be conducted whenever the actions of different peer review bodies are supported by substantially the same set of facts, even if the corrective actions or recommendations of the Medical Staffs, themselves, are different. If the corrective actions or recommendations are different, the Arbitrator (or Hearing Committee) shall apply the prescribed burden of proof to each action or recommendation for purposes of determining the results. A separate decision shall be issued by the Arbitrator (or Hearing Committee) to each participating peer review body with respect to its own actions and recommendations to the Practitioner involved.

## **Section 8.13 Applicability of Corrective Actions among UCLA Clinical Sites**

Unless otherwise expressly stated, any final decision following the procedures in this Article 8 shall apply and be enforced across each of the Practitioner's medical staff membership(s) at all UCLA-owned hospitals, the Practitioner's clinical activities at UCLA Clinics, and the Practitioner's membership in the UCLA Medical Group, as applicable.

## **ARTICLE 9 CLINICAL SERVICES**

### **Section 9.1 Organization of Clinical Services**

The Medical Staff shall be organized into Clinical Services. Each Service shall be organized as a separate component of the medical staff and shall have a Chief appointed and entrusted with the authority, duties, and responsibilities specified in Section 9.4.2. When appropriate, the Medical Staff Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of Services or Divisions.

### **Section 9.2 Clinical Services**

Clinical Services of the Medical Staff shall correspond to the Clinical Departments of the UCLA David Geffen School of Medicine and School of Dentistry, University of California, Los Angeles, and their organization shall be the same.

When the Clinical Service or any of its committees meets to carry out the duties described below, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal, state, and local law for peer review committees.

### **Section 9.3 Functions of Services**

The general functions of each Service shall include:

- (a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Service. The minimum number of such reviews to be conducted during the year shall be determined by the Medical Staff Executive Committee, in consultation with other appropriate committees. The Service shall routinely collect information about important aspects of patient care provided within the Clinical Service, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Service, regardless of whether the member whose work is subject to such review is a member of that Service.
- (b) Recommending to the Medical Staff Executive Committee criteria for the granting of clinical privileges and the performance of specified services within the Service.
- (c) Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking membership or renewal of membership and clinical privileges within that Service.
- (d) Conducting, participating and making recommendations regarding continuing education programs pertinent to Service clinical practice.
- (e) Reviewing and evaluating Service adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice.
- (f) Coordinating patient care provided by the Service's members with nursing and ancillary patient care services.
- (g) Submitting reports to the Medical Staff Executive Committee concerning: (1) the Service's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the Service and the hospital.
- (h) Meeting at least quarterly, constituting Regular meetings of the Medical Staff, for the purpose of considering patient care review findings and the results of the Service's other review and evaluation activities, as well as reports on other Service and staff functions.
- (i) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.
- (j) Formulating recommendations for Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Staff Executive Committee and the Medical Staff.

## **Section 9.4 Secondary Peer Review Committee for Other UCLA Hospitals**

Each Clinical Service at the Ronald Reagan-UCLA Medical Center shall also serve as a second level of peer review for its counterpart Clinical Service at Santa Monica-UCLA Medical Center whenever a case may benefit from a secondary review and is requested by one or both Service Chiefs.

## **Section 9.5 Service Chiefs**

The Chief of each Service shall be the Chair of the corresponding Department in the UCLA David Geffen School of Medicine, or Chair of the corresponding Division in the School of Dentistry, University of California, Los Angeles, or designate. The Chief is appointed by the Governing Body, on recommendation of the Dean of the UCLA David Geffen School of Medicine. The Chief is board certified, or has affirmatively established comparable competence through the credentialing process. Whenever a vacancy occurs, a search shall be conducted under the direction of the Dean.

### **9.5.1 Term of Office**

Each Service Chief shall serve until their successors are appointed, unless they resign, are removed from office, or lose their Medical Staff membership or clinical privileges in that Service prior to the appointment of a successor. In such circumstances, the Governing Body shall appoint an acting Service Chief to serve until a successor is appointed.

### **9.5.2 Duties**

- (a) The Chiefs of the individual Services shall be responsible to the Chief of Staff for the functioning of their Services, and shall have general supervision over the clinical work falling within those Services.
- (b) Each Chief of Service shall have the following authority, duties and responsibilities:
  - (1) Act as presiding officer at Service meetings;
  - (2) Report to the Medical Staff Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the Service;
  - (3) Monitor the quality of patient care and professional performance rendered by members with clinical privileges in the Service through a planned and systematic process; oversee and maintain the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Service by the Medical Staff Executive Committee in coordination and integration with organization-wide quality assessment and improvement activities;
  - (4) Develop and implement Service programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement and all other clinically related activities of the Service;

- (5) Be a member of the Medical Staff Executive Committee, and give guidance on the overall medical policies of the Medical Staff and hospital and make specific recommendations and suggestions regarding the Service;
- (6) Transmit to the Medical Staff Executive Committee the Service's recommendations concerning practitioner membership and classification, renewal of membership, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the Service;
- (7) Endeavor to enforce the Medical Staff Bylaws, Rules, Policies and Regulations within the Service;
- (8) Implement within the Service appropriate actions taken by the Medical Staff Executive Committee;
- (9) Participate in every phase of administration of the Service, including recommending a sufficient number of qualified and competent persons to provide care, treatment, and services, providing recommendations on facilities and other resources needed by the Service; cooperation with the nursing service and the hospital administration in matters such as personnel (including assisting in determining the qualifications and competence of Service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders, and techniques;
- (10) Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Service as may be required by the Medical Staff Executive Committee;
- (11) Assess and recommend to the Governing Body off-site sources for needed patient care, treatment, and services not provided by the Service or the Medical Center;
- (12) Integrate the Service into the primary functions of the hospital, and coordinate and integrate interdepartmental and intradepartmental services;
- (13) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services in the Service;
- (14) Provide orientation and continuing education of all persons in the Service;
- (15) Recommend delineated clinical privileges for each member of the Service; and
- (16) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Staff Executive Committee.

## **ARTICLE 10      OFFICERS**

### **Section 10.1    Titles of Officers**

The Officers of the Medical Staff shall be the Chief of Staff, the Vice Chief of Staff, the Secretary, and three members-at-large.

### **Section 10.2    Qualifications**

Officers must be members of the voting Medical Staff, are licensed physicians or surgeons at the time of their nominations and election, and must remain members in good standing during the term of their office. Failure to maintain such status shall immediately create a vacancy in the office involved.

### **Section 10.3    Term of Elected Office**

The officers shall each serve one 2-year term.

### **Section 10.4    Nominations**

The Medical Staff election year shall be every other even numbered Medical Staff year. Nominations for officers shall be made by the Nominating Committee, announced at the Medical Staff Executive Committee, and submitted to the voting Medical Staff for election.

### **Section 10.5    Election**

Officers shall be elected by a majority of the voting Medical Staff members via electronic ballot.

### **Section 10.6    Removal of Officers**

Any officer of the Medical Staff may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a Medical Staff Officer may be initiated by the Medical Staff Executive Committee or shall be initiated by a petition signed by at least twenty-five percent (25%) of the voting Medical Staff. Recall shall require a special meeting of the Medical Staff to be called for that purpose. Recall shall require a majority of voting Medical Staff present at the meeting.

### **Section 10.7    Vacancies**

A vacancy in the office of Chief of Staff, Vice Chief of Staff, Secretary or a member-at-large created by resignation, removal, death, or disability shall be filled by the Nominating Committee with the approval of the Medical Staff Executive Committee. This appointment shall be on an interim basis until the next regular election.

## **Section 10.8 Responsibilities of Medical Staff Officers**

### **10.8.1 Chief of Staff**

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

- (a) Enforcing the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- (b) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
- (c) Serving as Chair of the Medical Staff Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- (d) Serving as an *ex officio* member of all other staff committees without vote;
- (e) Interacting with the Chief Executive Officer in all matters of mutual concern within the Medical Center;
- (f) Appointing, in consultation with the Medical Staff Executive Committee, committee members for all standing committees other than the Medical Staff Executive Committee and all special Medical Staff committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairs of these committees;
- (g) Representing the views and policies of the Medical Staff to the Governing Body at every Governing Body meeting;
- (h) Being a spokesperson for the Medical Staff in external professional and public relations; and
- (i) Performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Staff Executive Committee.

### **10.8.2 Vice Chief of Staff**

The Vice Chief of Staff shall perform such duties of supervision as may be assigned by the Chief of Staff and shall be an *ex officio* member of all other Medical Staff committees. In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties of the Chief of Staff and have all the authority of the Chief of Staff.

### **10.8.3 Secretary**

The Secretary shall perform such duties of supervision as may be assigned by the Chief of Staff and shall be an *ex officio* member of all other Medical Staff committees. In the absence of the Chief of Staff and Vice Chief of Staff, the Secretary shall assume all duties of the Chief of Staff and have all the authority of the Chief of Staff.

#### **10.8.4 Members-At-Large**

The members-at-large shall perform such duties of supervision as may be assigned to them by the Chief of Staff and shall be *ex officio* members of all other Medical Staff committees. In the absence of the Chief of Staff, the Vice Chief of Staff and the Secretary, the chain of command shall be transferred to the Attending member-at-large in order of their length of time on the Medical Staff.

#### **10.8.5 Chain of Command**

In the absence of all the elected officers, the chain of command shall be transferred to the Chief of the Medicine Service followed by the Chief of Surgical Services. Each shall assume all duties of the Chief of Staff and have all the authority of the Chief of Staff.

### **ARTICLE 11 MEDICAL STAFF MEETINGS AND COMMITTEES**

#### **Section 11.1 Special Meetings**

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of The Regents of the University of California, the Governing Body, the Medical Staff Executive Committee, or 25% of the voting members of the Medical Staff.

At any Special Meeting, no business shall be transacted except that stated in the notice of the meeting. Sufficient notice of the meeting shall be communicated via electronic mail at least ten (10) working days before the set time of the meeting. A quorum at Special Meetings consists of those who attend the meeting.

#### **Section 11.2 Regular Meetings**

Each Clinical Service should hold Regular meetings for the purpose of, among others, evaluation of mortality (all deaths), major complications, and other elements of the clinical practice of the Service at the Medical Center. Minutes will be recorded to indicate those in attendance and to include a summary of the discussion of patients treated on that Service and resultant recommendations, conclusions, and/or actions instituted. The minutes of Clinical Service meetings shall be directed to the Peer Review Committee and reported to the Medical Staff Executive Committee. A quorum at Regular Meetings consists of those who attend the meeting. When the Clinical Service or any of its committees meets to carry out the duties described above, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal, state, and local law for peer review committees.

#### **Section 11.3 Minutes**

Except as otherwise specified herein, minutes of Medical Staff meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Staff Executive Committee.



## **Section 11.4 Conduct of Meetings**

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order however; technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

## **Section 11.5 Standing and Ad Hoc Committees**

Committees shall be Standing and Ad Hoc. All committees other than the Medical Staff Executive Committee shall be appointed by the Chief of Staff. All committee Chairs shall be appointed by the Chief of Staff unless otherwise specified. The Medical Staff shall maintain records of Standing and Ad Hoc Committee meetings.

In recognition of the common governance of UCLA Health through the UC Regents and to develop consistency in practice across the health system, certain committee functions shall be shared by appropriate Standing Committees of the Medical Staff of the Santa Monica-UCLA Medical Center and the Professional Staff of the Resnick Neuropsychiatric Hospital at UCLA. Representatives shall be appointed to such committees by the Chief of Staff as may be necessary. The Chief of Staff shall secure such minutes, reports, recommendations from such committees as may be required for review by the Medical Staff Executive Committee in order to assure compliance by the hospital staff and current standards, policies and procedures relevant to the specific functions shared. The shared functions shall not abrogate the ultimate authority and responsibility of the Chief of Staff for the performance of these functions.

### **11.5.1 Terms of Committee Members**

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

### **11.5.2 Removal**

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

### **11.5.3 Vacancies**

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if a Medical Staff member who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Staff Executive Committee.

### **11.5.4 Conflict of Interest**

All committee members must disclose in writing to the Medical Staff any personal, professional, or financial affiliations or responsibilities that would, or could reasonably be believed to, present a conflict of interest between the member and the subject, services or products under consideration. Such situations must be disclosed on appointment and when an actual or potential situation arises.

### **11.5.5 Composition**

The composition of committees shall consist of:

- (a) Voting members of the Medical Staff. Representatives for voting members may vote in their absence. Medical Staff members on these committees may only be represented by other Medical Staff members;
- (b) Non-voting Allied Health Staff members, Administrative, and ancillary personnel, as needed to conduct the business of the committee, and who are invited to attend all meetings as a result of their function; and
- (c) Residents who are appointed to a committee by the Chief of Staff. Only one vote will be accorded to the Residency Staff representation on a committee (other than the Medical Staff Executive Committee). When more than one resident is present, the Chair will designate one resident as the voting representative.

### **11.5.6 Quorum**

For committees, a quorum consists of those members who attend a meeting, provided reasonable notice has been given. When a quorum is present, a majority vote, that is a majority of the votes cast, is sufficient for the transaction of committee business.

### **11.5.7 Voting**

Voting on committee business may be accomplished in person or by electronic mail.

## **Section 11.6 Ad Hoc Committees**

Ad Hoc committees shall be appointed from time to time by the Chief of Staff as may be required to carry out properly the duties of the Medical Staff. Such committees shall confine their work to the purposes for which they were appointed, and shall report to the Medical Staff Executive Committee in writing. This report shall be accompanied by formal resolutions covering the recommendation of the committee, so that no further motion beyond adoption of the resolutions is necessary. Reporting relationships for Ad Hoc committees related to corrective action are specified in Article 7 of these Bylaws.

## **Section 11.7 Standing Committees**

### **11.7.1 Medical Staff Executive Committee**

The Medical Staff delegates to the Medical Staff Executive Committee the authority to perform on behalf of the medical staff all functions described in Sections 11.8.1(b) and Article 13.

#### **(a) Composition**

The Medical Staff Executive Committee shall consist of:

- (1) Officers of the Medical Staff;
- (2) Immediate past Chief of Staff;

- (3) Service Chiefs and the Directors of Emergency Medicine and the Clinical Lab;
- (4) Chief Medical Officer;
- (5) Direct reporting committee chairs (Credentials Committee, Clinical Excellence Committee, Risk Management Committee, Ethics Committee, and the Perioperative Surgical Services Committee);
- (6) Three members of the house staff or Chief Residents upon the recommendation of Service Chiefs shall serve *ex-officio* without vote; and
- (7) Hospital Administrators shall serve *ex-officio* without vote.

Whenever a new Clinical Service is created, its Chief shall become a member of the Medical Staff Executive Committee.

A Medical Staff Executive Committee member can be removed from the committee only if the Medical Staff acts to remove that member from the position held as an officer, in the manner provided in Section 10.6 for the recall of Officers, or, in the case of a Service Chief, in the manner provided in Section 9.4.1.

(b) **Duties**

The duties of the Medical Staff Executive Committee shall include:

- (1) Initiating, approving, and recommending to the Governing Body Medical Staff Bylaws, Rules and Regulations, Policies, and amendments and technical corrections thereto, in accordance with Article 13 of these Bylaws, of which approval shall not be unreasonably withheld.
- (2) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings within the scope of its responsibilities as defined by the Medical Staff and subject to such limitations as may be imposed by these Bylaws;
- (3) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
- (4) Receiving and acting upon reports and recommendations from Medical Staff Clinical Services, Divisions, committees, and assigned activity groups;
- (5) Recommending actions to the Governing Body on matters of a medical-administrative nature;
- (6) Developing and adopting appropriate hospital policies to enable privileges holders to maintain the level of practice required under, and to more specifically implement, these Bylaws;
- (7) Evaluating the medical care rendered to patients in the hospital;
- (8) Participating in the development of all hospital policy, practice, and planning;

- (9) Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Governing Body at least quarterly regarding staff membership and renewals of membership, assignments to Services, clinical privileges, and corrective action;
- (10) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;
- (11) Taking reasonable steps to develop continuing education activities and programs for the Medical Staff;
- (12) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;
- (13) Reporting to the Medical Staff at each Regular staff meeting;
- (14) Assisting in the obtaining and maintenance of accreditation;
- (15) Developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;
- (16) Appointing such Special meetings or Ad Hoc committees as may seem necessary or appropriate to assist the Medical Staff Executive Committee in carrying out its functions and those of the Medical Staff;
- (17) Establishing a mechanism for dispute resolution between Medical Staff members involving the care of a patient;
- (18) Initiating a conflict management process to address disagreements between members of the Medical Staff and the Medical Staff Executive Committee on issues including but not limited to proposals to remove some authority delegated to the Medical Staff Executive Committee by the Medical Staff under these Bylaws (by amending the Bylaws); or to adopt or revise Rules and Regulations, or Policies; and
- (19) Fulfilling such other duties as the Medical Staff has delegated to the Medical Staff Executive Committee in these Bylaws.

(c) **Meetings**

The Medical Staff Executive Committee shall meet as often as necessary, but at least ten times a year and maintain a permanent record of its proceedings and actions.

(1) **Executive Session**

Executive session is a meeting which only medical staff members may attend, unless others are expressly requested by the member presiding at the meeting to

attend. Executive session may be called to discuss peer review issues, or any other sensitive issues requiring confidentiality.

(d) **Reports**

(1) Reports are transmitted to the Governing Body four times a year by the Medical Staff Executive Committee, including:

- Medical Staff performance improvement, opportunities, and obstacles;
- High profile administrative matters and policy;
- High profile Clinical Service matters and policy; and
- Recommendations for services, space, and resources

(2) Committees directly reporting to the Medical Staff Executive Committee include:

- Bylaws Committee;
- Credentials Committee;
- Medical Risk Management Committee;
- Clinical Excellence Committee;
- Medical Staff Health Committee;
- Ethics Committee;
- Nominating Committee;
- Perioperative Surgical Services Committee; and
- Utilization Review Committee

**11.7.2 Bylaws Committee**

(a) **Composition**

The Bylaws Committee shall consist of one voting Medical Staff member from, at least, each of the primary Services:

- Medicine;
- Surgery;
- Pediatrics; and
- The Chief Medical Officer.

(b) **Duties**

The duties of the Bylaws Committee shall include:

- (1) Conducting reviews of the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures;
- (2) Developing and submitting recommendations to the Medical Staff Executive Committee for changes in these documents, as necessary, to reflect current Medical Staff practices;
- (3) Reviewing hospital policies for clinical relevance and appropriateness as well as inconsistencies and conflicts with Medical Staff Rules and Policies and reporting

issues and recommendations to the Medical Staff Executive Committee for its review; and

- (4) Ensuring that the Medical Staff Bylaws and Rules and Regulations are consistent with those of the Governing Body.

(c) **Meetings**

The Bylaws Committee shall meet as often as necessary and report its recommendations to the Medical Staff Executive Committee.

### **11.7.3 Credentials Committee**

(a) **Composition**

The Credentials Committee shall consist of at least, but not be limited to:

- Medical Staff members representing primary Services;
- A representative from the UCLA Medical Group;
- The Chair of the Graduate Medical Education Committee; and
- The Chair of the Interdisciplinary Practice Committee.

(b) **Duties**

The duties of the Credentials Committee shall include:

- (1) Reviewing and evaluating the qualifications of each practitioner applying for initial appointment, reappointment, or modification of clinical privileges, and obtaining and considering Service recommendations.
- (2) Submitting required reports on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, Service/Division affiliation, clinical privileges and special conditions.
- (3) Investigating, reviewing and reporting on matters referred by the Chief of Staff or the Medical Staff Executive Committee regarding the qualification, conduct, professional character, ethics or competence of any applicant or Medical Staff member; and
- (4) Reviewing, evaluating, acting upon and submitting conclusions and recommendations for further action related to the content contained with referrals from the following committees:
  - Peer Review Committee;
  - Interdisciplinary Practice Committee;
  - Medical Staff Health Committee;
  - Graduate Medical Education Committee; and
  - Any Ad-Hoc committees appointed to investigate quality of care of a practitioner.

(c) **Meetings**

The Credentials Committee shall meet as often as necessary but at least ten (10) times a year. The committee shall maintain a record of its proceedings and actions and submit reports to the Medical Staff Executive Committee.

**11.7.3.1 Peer Review Committee**

(a) **Composition**

The Peer Review Committee shall consist of members of the Medical Staff, representing primary Services including:

- Medicine;
- Surgery; and
- Pediatrics.

(b) **Duties**

The Peer Review Committee shall be an ad hoc committee that meets only when there is a specific need including:

- (1) Providing oversight over Service peer review activities regarding members whose practice has been questioned, ensuring fairness at the request of the member, Service, or Chief of Staff;
- (2) Providing input on UCLA Health quality initiatives that may affect the practice of the Medical Staff; and
- (3) Reviewing any other medical staff performance issues deemed appropriate by the Chief of Staff.

(c) **Meetings**

The Peer Review Committee shall meet on an ad hoc basis and submit reports to the Clinical Excellence and Medical Staff Executive Committees as appropriate.

**11.7.3.2 Interdisciplinary Practice Committee**

(a) **Composition**

The Interdisciplinary Practice Committee shall consist of an equal number of Medical Staff and Nursing Staff members (including a designee of the Director of Nursing), as well as representatives from other categories of Allied Health Professionals. The Chair of the committee shall be a member of the voting Medical Staff appointed by the Medical Staff Executive Committee.

(b) **Duties**

The duties of the Interdisciplinary Practice Committee shall include:

- (1) Providing Medical Staff oversight as well as fulfilling State of California requirements related to performance of standardized procedures by advance practice nurses and privileging of licensed independent practitioners who are not members of the Medical Staff;
- (2) Developing and reviewing standardized policies that apply to advanced practice nurses;
- (3) Developing and reviewing requests for standardized procedures that apply to policy and approve same periodically. Such policies and procedures shall, at the minimum, be related to standardized procedures for:
  - Assessing patients; and
  - Planning treatments.
- (4) Fulfilling the “Committee on Interdisciplinary Practice” function required by California’s Code of Regulations, Title 22, pursuant to which the Committee establishes and implements policies and procedures for application, review and approval of registered nurses functioning in expanded roles and/or performing standardized procedures outside of their scope of practice. In addition, assuring that the Standardized Procedures are a collaborative effort among administration and health professionals, including nurses and physicians. Report findings, conclusions, recommendations and actions taken to address matters related to policies and procedures to the Credentials Committee;
- (5) Reviewing all Allied Health Professional applications and requests for standardized procedures and privileges and forwarding recommendations to the Credentials Committee;
- (6) Participating in performance improvement and patient safety activities as related to ongoing professional practice evaluations provided on all allied health practitioners; and
- (7) Initiating or recommending corrective action, when indicated, in accordance with the Medical Staff Bylaws.

(c) **Meetings**

The Interdisciplinary Practice Committee shall meet as often as necessary but at least ten (10) times a year and submit reports to the Credentials Committee.

**11.7.4 Medical Staff Health Committee**

(a) **Composition**

The Medical Staff Health Committee shall be comprised of Active, Courtesy, or Consultant members of the Medical Staff; and if appropriate and available, a community member. It shall be chaired by a physician member of the Medical Staff.



No member of this Committee may serve simultaneously on the Medical Staff Executive Committee, the Credentials Committee, or a Clinical Service peer review committee.

(b) **Duties**

The Medical Staff Health Committee supports the wellbeing and health of the members with the aim of protecting patient welfare, advancing patient care, fostering a culture of safety, and improving member function.

The committee offers confidential assistance to any Medical Staff member by creating an environment and consultation mechanisms that is conducive to referral, self-referral and rehabilitation of members who may be suffering from a medical, cognitive, psychiatric, behavioral, or substance-use related problem that may potentially pose a threat to patient care, self and/or others.

The committee, having educated the Medical Staff in recognizing physician impairment and compromise, shall receive, investigate, and evaluate the referrals to determine credibility, and advise the Chief of Staff if the physical, mental health, or behavior of the medical staff member impairs their ability to function, or poses unreasonable risk or harm to patients, themselves, or other staff members.

If an impairment may exist, the committee will advise the Chief of Staff or their delegate as soon as possible. The committee shall offer assistance in referral to appropriate evaluation and treatment resources.

The committee shall monitor the affected member through the entire rehabilitation period. Confidentiality of the member seeking referral or referred for assistance shall be kept, except as limited by law, ethical obligation, or when the safety of a patient is at risk.

In instances in which a member poses unreasonable risk of harm to patients or health care team members, the committee shall report all instances to the Medical Staff Executive Committee. The committee is not disciplinary in nature and does not preclude other review mechanisms set forth in these Bylaws.

The committee shall also consider general matters related to the health and wellbeing of the Medical Staff. With the approval of the Medical Staff Executive Committee, the committee shall develop educational programs or related activities to improve physician health and wellness, prevention and interventions of conditions and behaviors that undermine a culture of safety.

(c) **Meetings**

This Committee shall meet as often as necessary, but at least quarterly, and report a summary of its activities to the Medical Staff Executive Committee. Additionally, committee members shall meet for ad hoc meetings with new referrals throughout the year, or for phone consultations regarding those individuals being monitored by the committee. This committee shall be empowered to meet in executive session, during which records need not be kept. Medical Staff members under discussion by this committee shall not be identified in committee records.

### **11.7.5 Risk Management Committee**

#### **(a) Composition**

The Risk Management Committee shall include members of various Medical Staff services as deemed appropriate by the Committee, as well as representatives from the Medical Center and/or UCLA Health Administration, UCLA Medical Group, and Nursing Administration. In addition, the Risk Management Committee shall include representatives from UCLA Health Risk Management. Invited guests may include providers and staff involved in claims and lawsuits involving UCLA patients and/or UCLA providers, their applicable Service Chiefs, and/or supervisors (or designees) as well as legal counsel and representatives from the Third Party Administrator.

#### **(b) Duties**

The duties of the Risk Management Committee shall include:

- (1) Review clinical management of patients involved in significant claims and lawsuits. Alert appropriate committees/departments to issues. Propose process improvements to intended committees/departments to improve patient quality and safety by minimizing risk and preventing or reducing reoccurrence. Evaluate whether the standard of care has been met in appropriate circumstances and provide input on complex medical issues;
- (2) Review and report on professional liability complaints that involve UCLA Health or its medical staff and determine whether or not the standard of care was met;
- (3) Identify and reduce practices that can lead to organizational and professional liability and legal exposure;
- (4) Assure that potential sources of professional liability claims for correction and prevention are identified;
- (5) Report all risk surveillance, prevention and control findings that impact on quality of care to the designated committees; and
- (6) Report to the Medical Staff Executive Committee identified conduct that adversely affects patient care and wellbeing.

#### **(c) Meetings**

The Risk Management Committee shall meet as necessary and submit reports to the Medical Staff Executive Committee.

### **11.7.6 Ethics Committee**

#### **(a) Composition**

Members of the Ethics Committee shall include but not be limited to voting Medical Staff, four of which represent different Services, and representatives from:

- Nursing;
- Social Services;
- Ethics;
- Hospital administration; and
- The Community

(b) **Duties**

The duties of the Ethics Committee shall include:

- (1) Serving as an advisory committee to the Medical Staff and its committees;
- (2) Developing criteria and guidelines for the consideration of cases having bioethical implications;
- (3) Developing and implement procedures for the review of cases having bioethical implications;
- (4) Developing and/or reviewing institutional policies regarding care and treatment in cases having bioethical implications;
- (5) Retrospectively reviewing selected cases for the purpose of determining the usefulness of, and to further refine, institutional bioethical policies;
- (6) Consulting with concerned parties when ethical conflicts occur in order to facilitate communication and decision making;
- (7) Providing a process for conflict resolution;
- (8) Educating Medical Center staff regarding policies and issues of a bioethical nature; and
- (9) Establishing and publicizing a procedure by which any interested party may notify the committee of a pressing immediate problem on an expedited basis.

(c) **Meetings**

The Ethics Committee shall meet at least bimonthly, or more often as necessary. Due to its interdisciplinary nature, all members of the committee are eligible to vote on committee business.

**11.7.7 Nominating Committee**

The Nominating Committee is comprised of the immediate past Chief of Staff who shall serve as Chair, and three members of the Medical Staff to be appointed by the Medical Staff Executive Committee. The Nominating Committee shall nominate the Medical Staff Officers.

The Nominating Committee shall meet every two years and develop a slate of candidates which shall be presented to the Medical Staff as nomination for Officers for the upcoming Medical Staff year.

## **11.7.8 Clinical Excellence Committee**

### **(a) Composition**

The Clinical Excellence Committee shall include, but not be limited to:

- Members of the voting Medical Staff;
- Risk Management Committee Chair;
- Nursing Representative;
- UCLA Medical Group Representative;
- Representative from the Center for Patient Safety; and
- Chief Medical Officer.

Chairs of the committees reporting to the Clinical Excellence Committee may be asked to participate in meetings as appropriate.

### **(b) Role**

The role of the Clinical Excellence Committee is to provide quality, safety, and performance improvement leadership as delineated in the Performance Improvement/Patient Safety Plan. The Committee ensures that all national standards are met, appropriate monitors put in place, and reports presented regularly to keep the leadership informed of compliance with standards. The committee will assist Medical Staff leadership in prioritizing where resources should be allocated.

### **(c) Meetings**

The Clinical Excellence Committee shall meet monthly and submit reports to the Medical Staff Executive Committee.

### **(d) Reports**

Written reports shall include the following:

- Report of changes to any priorities;
- Identified performance improvement opportunities related to clinical care;
- Performance improvement opportunities of an operational nature that need Medical Staff Executive Committee input for resolution ;
- Response to any queries or issues raised by Medical Staff Executive Committee;
- Readiness for regulatory and accreditation surveys;
- Organizational compliance with internal and external standards;
- Assessment of Performance Improvement successes and remaining challenges; and
- Recommendations for annual priority settings

Committees reporting to the Clinical Excellence Committee include, but not limited to:

- Blood and Blood Derivatives Committee;
- Critical Care Committee;
- Dietary/Nutrition Committee;
- Emergency Care Committee;

- Incident Review Committee;
- Infection Control Committee;
- Pharmacy and Therapeutics Committee;
- Stroke Committee;
- Surgical/Invasive Procedures Committee;
- Trauma Patient Care Committee; and
- Ambulatory Incident Review Committee

Functions reporting to the Clinical Excellence Committee include:

- Medical Records

#### **11.7.8.1 Blood and Blood Derivatives Committee**

**(a) Composition.**

The Blood and Blood Derivatives Committee may include but not be limited to members of the Medical Staff representing:

- Anesthesiology;
- Pediatrics;
- Medicine;
- Surgery;
- OB /GYN;
- Orthopedic Surgery;
- Pathology (Transfusion Nursing); and
- Representatives from Nursing.

**(b) Duties.**

The duties of the Blood and Blood Derivatives Committee shall include:

- (1) Reviewing administration of blood and its derivatives within the Medical Center to ensure that these substances are being used wisely;
- (2) Identifying, evaluating, confirming and reporting all untoward transfusion reactions occurring in the hospital and informing the Medical Staff when appropriate;
- (3) Conducting investigations, as needed;
- (4) Conducting audit of adverse apheresis events;
- (5) Conducting audit and reviewing practices of the Stem Cell Laboratory;
- (6) Assisting and overseeing the formulation of professional practices and policies regarding the ordering, distributing, handling, dispensing, administering, monitoring the effects of blood and its derivatives on patients, as well as safety procedures, and all other matters relating to blood in the hospital;
- (7) Evaluating and measuring administration of blood and its derivatives, in accordance with medical staff-approved criteria governing its use and reporting

findings as related to occurrences when blood is administered when not indicated, not administered when indicated; and administered incorrectly;

- (8) Reviewing the transfusion practice of the Medical Staff;
- (9) Designing a comprehensive performance improvement program, executing on-going performance measures, guiding implementation of improvements, as warranted for the following processes related to the usage of blood and its derivatives as appropriate which may include:
  - Ordering;
  - Distributing, handling, dispensing;
  - Administering; and
  - Monitoring the effects of blood and its derivatives on patients.

(c) **Meetings.**

The Blood and Blood Derivatives Committee shall meet at least quarterly, or more often as necessary.

(d) **Reports.**

Reports are transmitted to the Clinical Excellence Committee. Semi-annual reports shall include:

- (1) Summary report of new/revised policies, protocols and standards for Medical Staff Executive Committee evaluation and approval
- (2) Summary of measured performance improvement findings, conclusions, recommendations and actions already taken, as related to:
  - Transfusion reactions;
  - Appropriateness of blood administration;
  - The four (4) blood processes that will be continually measured.
- (3) Summary of actions that the Blood and Blood Derivatives Committee is requesting the Clinical Excellence Committee to:
  - Approve; and/or
  - Initiate to help the Blood and Blood Derivatives Committee resolve related matters.

### **11.7.8.2 Critical Care Committee**

(a) **Composition.**

The Critical Care Committee shall include but not be limited to members of the Medical Staff, Directors of each of the Medical Center intensive care and emergency units; and representatives from:

- Nursing;
- Respiratory Therapy;
- Clinical Labs;
- Pharmacy; and
- Admissions and Registration.

(b) **Duties.** The duties of the Critical Care Committee shall include:

- (1) Evaluating the standard of critical care practice for various intensive care and emergency units in the hospital;
- (2) Evaluating the training of medical personnel to appropriately manage care in these areas;
- (3) Coordinating CPR instruction and certification for the Medical Staff in collaboration with Medical Center Administration;
- (4) Tracking and trending results of Codes to ensure that effective resuscitation services are systematically available throughout the hospital;
- (5) Recommending medical policies relevant to the operation of the critical care units and the care of patients;
- (6) Recommending nursing policies relevant to the operation of the critical care units and the care of patients;
- (7) Recommending the purchase of equipment needed to provide safe and quality care to patients located in the critical care areas;
- (8) Recommending methods for more effective bed utilization; and
- (9) Determining what Performance Improvement and patient safety activities the Committee should assume if service-based programs are changing.

(c) **Meetings.**

The Critical Care Committee shall meet at least quarterly or more often as necessary.

(d) **Reports.**

Reports are transmitted to the Clinical Excellence Committee. Written reports shall include:

- (1) Summary report of new or revised policies, protocols and standards for evaluation and approval.
- (2) Summary of measured performance improvement findings, conclusions, recommendations and actions already taken, as related to:
  - (i) Specific performance measures associated with the evaluation of the standard(s) of critical care practice for intensive and emergency care units;

- (ii) Addressing the identified training needs of personnel to manage care in critical care areas;
- (iii) The effectiveness of such education; and
- (iv) The needs and status of CPR instruction and certification for the medical staff.

**11.7.8.3 Emergency Care Committee**

**(a) Composition.**

The Emergency Care Committee shall include but not be limited to members of the Medical Staff and representatives from the following:

Emergency Med	Anesthesiology	Dentistry
Medicine	Neurology	OB/GYN
Ophthalmology	Pediatrics	Psychiatry
Radiology Sciences	Surgical Services	House Officers
Critical Care Nursing	OR Nursing	EM Nursing Director
Med Center Admin.		

**(b) Duties.**

The duties of the Emergency Care Committee shall include:

- (1) Reviewing the use of the Emergency Department;
- (2) Assuring organization of optimal methods for prompt efficient medical and surgical management of patients presenting to the Ronald Reagan UCLA Medical Center for unscheduled immediate care;
- (3) Evaluating the training of medical personnel in the management of and service rendered to trauma patients; and
- (4) Recommending policies, protocols and standards for the management of trauma patients.

**(c) Meetings.**

The Emergency Care Committee shall meet at least quarterly or more often as necessary.

**(d) Reports.**

Reports are transmitted to the Clinical Excellence Committee. Semi-annual reports shall include:

- (1) Summary report of new/revised policies for Clinical Excellence Committee evaluation and approval;
- (2) Summary of findings, conclusions, recommendations and actions already taken, as related to:



- (i) Defined performance measures related to the use of the Emergency Medicine Center; and
  - (ii) Defined performance measures of timeliness and efficient surgical and medical management of Emergency Medicine Center patients.
- (3) Summary of actions that the Emergency Care Committee is requesting the Clinical Excellence Committee to:
- (i) Approve; and/or
  - (ii) Initiate actions to help the Emergency Care Committee resolve the emergency care related matters.

#### **11.7.8.4 Pharmacy and Therapeutics Committee**

(a) **Composition.**

The Pharmacy and Therapeutics Committee shall consist of members of the Medical Staff representing Medicine, Surgery, Pediatrics, OB/Gyn, Psychiatry, and Dentistry, and representation, with voting rights from Nursing, the Pharmacy Director, Nutrition, and Administration, as applicable. The Chief of Staff shall appoint the Chair and the Chair will appoint the members to the Pharmacy and Therapeutics Committee.

(b) **Duties.**

Responsibilities of the Pharmacy and Therapeutics Committee shall include:

- (1) Establish, develop and maintain a unified UCLA Health-wide Drug Formulary, including the establishment of criteria-for-use for formulary and non-formulary agents;
- (2) Assess the effectiveness, cost, benefit, and safety of the Drug Formulary to the UCLA Health population and to the institution. Implement, support, and monitor compliance with formulary guidelines and cost avoidances initiatives;
- (3) Provide oversight of the development and evaluation of UCLA Health medication use policies;
- (4) Establish pharmacological management guidelines for specific disease states as required;
- (5) Provide oversight of pharmacy operations and medication safety;
- (6) Provide oversight of the Pharmacy and Therapeutics Subcommittees:
  - (i) Antibiotic subcommittee; and
  - (ii) Medication Event Committee(s)
- (7) Recommend, review and approve medication order sets within the electronic medical record system, including modifications and enhancements;

- (8) Provide oversight for the performance of evidence-based, therapeutic drug class reviews that may lead to further Drug Formulary standardization;
- (9) Provide oversight for the management of drug shortages and drug recalls;
- (10) Perform all functions required in the most current Joint Commission Accreditation Manual for Hospitals and conform to current laws and regulations as set forth in California Code of Regulations, Title 22 and other applicable rules and regulations as outlined by the California Department of Public Health;
- (11) Monitor non-formulary drug use and provide the information and/or mechanisms for improvement to the Medical Staff Executive Committee;
- (12) Monitor and trend Adverse Drug Events (ADEs) to identify opportunities for future improvement and avoidance. Provide trended information to the Medical Staff Executive Committee; and
- (13) Monitor Medication Events and develop policies and procedures to minimize or eliminate them via the Medication Event Committee(s).

(c) **Meetings.**

The Pharmacy and Therapeutics Committee shall meet at least ten times per year. The quorum shall consist of a majority of voting Medical Staff members present.

(d) **Reports.**

Reports are transmitted to the Clinical Excellence Committee. Quarterly written reports shall include:

- (1) Summary report of new/revised policies for the Clinical Excellence Committee's evaluation/approval;
- (2) Summary of findings, conclusions, recommendations and actions already taken, as related to:
  - (i) Formulary review and non-formulary medications approved;
  - (ii) Activities related to investigational drugs and research protocols; and
  - (iii) Performance Improvement activities, as related to Adverse Drug Reactions ("ADRs"), medication errors, Clinical Intervention Program, as well as the four (4) medication processes that will be continually measured.
- (3) Summary of actions that the Pharmacy and Therapeutics Committee is requesting the Clinical Excellence Committee to:
  - (i) Approve; and/or
  - (ii) Initiate to help the Pharmacy and Therapeutics Committee resolve the medication and pharmacy related matters.

The Pharmacy and Therapeutics Committee will report quarterly, through the Clinical Excellence Committee, to the Medical Staff Executive Committee a summary of findings,

conclusions, recommendations and actions already taken, as appropriate which may include:

- Prescribing and ordering;
- Preparing and dispensing;
- Administering; and
- Monitoring the effects on patients.

#### **11.7.8.5 Trauma Patient Care Committee**

(a) **Composition.**

The Trauma Patient Care Committee shall include but not be limited to members of the Medical Staff, the Trauma Program Director, the Trauma Nurse Coordinator, and representatives from:

- Emergency Medicine;
- Surgical Services;
- Orthopedic Surgery;
- Anesthesiology;
- Radiology;
- Neurology; and
- Nursing, Clinical Social Work, and Administration.

(b) **Duties.** The duties of the Trauma Patient Care Committee shall include:

- (1) Serving as an interdisciplinary Clinical Excellence Committee;
- (2) Overseeing quality of trauma patient care;
- (3) Evaluating service rendered to trauma patients;
- (4) Recommending policies, protocols and standards for the management of trauma patients; and
- (5) Continuously improving clinical and operational processes and patient outcomes

(c) **Meetings.**

The Trauma Patient Care Committee shall meet at least quarterly or more often as necessary.

(d) **Reports.**

Reports are transmitted to the Clinical Excellence Committee. Semi-annual reports shall include:

- (1) Summary report of new or revised policies, protocols and standards for Clinical Excellence Committee evaluation and approval;

- (2) Summary of findings, conclusions, recommendations and actions already taken, as related to:
  - (i) Defined performance measures related to the care processes, systems and outcomes of trauma care;
  - (ii) Defined performance measures of timeliness and efficient management of trauma care being provided to patients.
- (3) Summary of actions that the Trauma Patient Care Committee is requesting the Clinical Excellence Committee to:
  - (i) Approve; and/or
  - (ii) Initiate to help the Trauma Patient Care Committee resolve related matters.

#### 11.7.8.6 **Infection Control Committee**

(a) **Composition.**

The Infection Control Committee shall include but not be limited to members of the Medical Staff and representatives from:

- Medicine;
- Pediatrics;
- Ophthalmology;
- OB/Gyn;
- Surgery; and
- Clinical Microbiology;

(b) **Role.**

The purpose of the Infection Control Committee is to direct the design and implementation of all infection avoidance and management policies, procedures, processes and improvements, related to the following:

- (1) Infection Control surveillance;
- (2) Infection Control prevention; and
- (3) Control of Infection.

Specific responsibilities shall include:

- (1) Developing a hospital-wide infection control program, including policies and procedures and maintaining surveillance of the program;
- (2) Developing a system for reporting, identifying 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;

- (3) Developing and implementing a preventative and corrective program designed to minimize infection hazards, including establishing, reviewing and /or evaluating aseptic, isolation and sanitation techniques;
- (4) Developing written policies defining special indications for isolation requirements;
- (5) Acting in an advisory capacity, detailing trends in antimicrobial resistance to the Antibiotic Subcommittee for consideration and action;
- (6) Acting upon recommendations related to infection control received from the Chief of Staff, the Medical Staff Executive Committee, Services, Divisions and other committees;
- (7) Reviewing sensitivities of organisms specific to the facility;
- (8) Carrying out quality/ performance measurement assessment and improvement activities to promote a safe environment for Ronald Reagan UCLA Medical Center;
- (9) Reporting all infection-related surveillance, prevention and control findings that will have an impact on the quality of care to the designated committees, as defined in these Bylaws.

(c) **Meetings.**

The Infection Control Committee shall meet at least quarterly or more often as necessary.

(d) **Reports.**

Reports are transmitted to the Clinical Excellence Committee. Semi-annual reports shall include:

- (1) Summary report of new / revised policies for Medical Staff Executive Committee evaluation and approval;
- (2) Summary of findings, conclusions, recommendations and actions already taken to address infection-related surveillance, prevention and control activities;
- (3) Summary of actions that the Infection Control Committee is requesting the Clinical Excellence Committee to:
  - (i) Approve; and/or
  - (ii) Initiate to help the Infection Control Committee resolve the infection-related matters.

### **11.7.8.7 Surgical/Invasive Procedures Committee**

(a) **Composition.**

The Surgical/Invasive Procedures Committee may include but not be limited to members of the Medical Staff and representatives from:

- Surgery;
- Medicine;
- Pediatrics;
- OB/Gyn;
- Orthopedic Surgery;
- Pathology;
- Radiology; and
- Urology.

(b) **Duties.** The duties of the Surgical/Invasive Procedures Committee shall include:

- (1) Reviewing selected operative, other invasive and non-invasive procedures performed on inpatients and outpatients;
- (2) Assisting and overseeing the formulation of professional practices and policies regarding the operative, other invasive, and non-invasive procedures performed on inpatients and outpatients as well as safety procedures, and all other matters relating to surgery in the Medical Center;
- (3) Evaluating and measuring the performance of operative, other invasive, and non-invasive procedures performed on inpatients and outpatients in accordance with medical staff-approved criteria governing these interventions and report findings as related to occurrences when these procedures are:
  - (i) performed when not indicated;
  - (ii) not performed when indicated; or
  - (iii) performed poorly or incorrectly.
- (4) Designing a comprehensive performance improvement program, executing on-going performance measures to guide the implementation of improvements, for the following processes related to the operative, other invasive, and non-invasive procedures performed on inpatients and outpatients:
  - (i) Selection of the appropriate procedure;
  - (ii) Patient preparation for the procedure;
  - (iii) Performance of the procedure and patient monitoring;
  - (iv) Post-procedure care;
  - (v) Post-procedure patient education; and
  - (vi) Conduct investigations, as needed.

(c) **Meetings.** The Surgical/Invasive Procedures Committee shall meet at least quarterly or more often as necessary.

(d) **Reports.** Reports are transmitted to the Clinical Excellence Committee. Semi-annual reports shall include:

- (1) Summary report of new or revised policies, protocols and standards for the Clinical Excellence Committee evaluation and approval

- (2) Summary of measured performance improvement findings, conclusions, recommendations and actions already taken, related to the operative, other invasive and non-invasive procedures performed on inpatients and outpatients:
  - (i) performed when not indicated;
  - (ii) not performed when indicated; or
  - (iii) performed poorly or incorrectly.
  
- (3) Summary of measured performance improvement findings, conclusions, recommendations and actions already taken, as related for the following processes related to the operative, other invasive and non-invasive procedures performed on inpatients and outpatients as appropriate which may include:
  - (i) Selection of the appropriate procedure;
  - (ii) Patient preparation for the procedure;
  - (iii) Performance of the procedure and patient monitoring;
  - (iv) Post-procedure care; and
  - (v) Post-procedure patient education

### **11.7.9 Perioperative Surgical Services Committee**

#### **(a) Composition.**

The Perioperative Surgical Services Committee shall include but not be limited to voting members of the Medical Staff and voting members of Medical Center Administration:

- Service Chief, Anesthesiology and Perioperative Medicine (Co-Chair);
- Elected Division/Service Chief of a surgical service (Co-Chair);
- Service Chief, Surgery;
- Service Chief, Head & Neck Surgery;
- Service Chief, Neurosurgery;
- Service Chief, Obstetrics & Gynecology;
- Service Chief, Ophthalmology;
- Service Chief, Orthopedic Surgery;
- Service Chief, Urology;
- Vice Service Chief, Anesthesia;
- Chief Medical Officer, Ronald Reagan UCLA Medical Center;
- Chief Medical Officer, Santa Monica-UCLA Medical Center;
- Chief Medical and Quality Officer, UCLA Health;
- Chief Operating Officer, UCLA Health;
- Chief of Operations for Ambulatory & Community Practices, UCLA Health;
- Chief Nursing Executive, UCLA Health;
- Chief Financial Officer, UCLA Hospital System;
- Medical Director, Operating Room Services; and
- Executive Director of Perioperative Services, UCLA Health.

#### **(b) Duties.**

The Perioperative Surgical Services Committee shall:

- Coordinate medical and hospital activity within Perioperative Services;
- Track, monitor, and report Perioperative Services performance indicators such as block time utilization, block release timing, service volumes, and other related metrics;
- Provide recommendations to address and improve performance;
- Review and act upon work team findings and recommendations;
- Establish policies and guidelines for standard operational procedures to assure quality, efficiency and compliance with regulatory guidelines;
- Develop enforcement mechanisms for all established policies;
- Ensure collaboration between nursing, surgeons, anesthesiologists and the UCLA Health system as it relates to Surgical Services operations;
- Serve as a forum to facilitate multidisciplinary communications and a means to resolve interdisciplinary issues;
- Support, develop and facilitate innovative surgical care and identify capital needs and make recommendations to the UCLA Health President's Council, the Chief Financial Office, or the Chief Operating Officer; and
- Provide oversight for the ongoing Quality Assurance of Surgical Services Quality Committees

(c) **Meetings.**

The Perioperative Surgical Services Committee shall meet at least quarterly or more often as necessary and submit reports to the Medical Staff Executive Committee.

### 11.7.10 Utilization Review Committee

(a) **Composition**

- Physician members of the voting Medical Staff representing the major clinical services of the medical center, including one representative without vote from Quality Assurance Utilization Review.
- The Committee will have representation from advisors from case management/utilization review, performance excellence, data management, HIMS, nursing, patient financial services, and medical center administration

(b) **Duties**

- Conduct utilization review studies designed to evaluate the appropriateness of admissions to the Medical Center, lengths of stay, discharge practices, use of medical and Medical Center services, and all related factors which may contribute to the effective utilization of Medical Center and physician services.
- Analyze the effect of utilization of each of the Medical Center's services on quality and appropriateness of patient care, study patterns of care, obtain criteria relating to average or normal lengths of stay by specific disease categories, and evaluate systems of utilization review employing these criteria
- Monitor continuity of care upon discharge through evaluation of discharge planning activities.



- Formulate and review annually a written Utilization Management Plan for the Medical Center
- Assist, as needed, in the review activities of non-physician reviewers
- Evaluate the medical necessity for continued Medical Center services when indicated

(c) **Meetings**

The Utilization Review Committee shall meet at least quarterly and submit reports to the Medical Staff Executive Committee.

## **ARTICLE 12                      CONFIDENTIALITY**

### **Section 12.1   Confidentiality of Information**

The discussions, deliberations, records, and other information of the Medical Staff, Clinical Services, Divisions, and/or their committees, shall be confidential to the fullest extent permitted by law. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or in the absence of any officially adopted policies, only with the express approval of the Medical Staff Executive Committee or its designee.

A signed confidentiality agreement will be required of all attendees at Medical Staff committee meetings.

### **Section 12.2   Breach of Confidentiality**

Effective quality assessment activities, peer review, and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid communication. Accordingly, any breach of the confidentiality of discussions, deliberations, records, and other information generated in connection with these activities of the Medical Staff, Clinical Services, Divisions, or their committees is outside appropriate standards of conduct for Medical Staff members and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, corrective action may be undertaken, as deemed appropriate. In particular, and without limitation, a breach includes any unauthorized testimony or unauthorized offer to testify before a court of law or in any proceeding, as to matters protected by this confidentiality provision and/or applicable law.

Safeguarding confidential information is a fundamental obligation for all Medical and Allied Health Staff members. Protected health information includes, but is not limited to, any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. Any breach of confidentiality is outside appropriate standards of conduct for Medical and Allied Health Staff members. If it is determined that such a breach has occurred, the Medical Staff Executive Committee may undertake such corrective action as it deems appropriate.

### **Section 12.3 Retaliation Prohibited**

Neither the Medical Staff, the Governing Body, its Chief Executive Officer, nor any other employee or agent of the Medical Center, may engage in any punitive or retaliatory action against any member of the Medical Staff because that member claims a right or privilege afforded by, or seeks implementation of, any provision of these Medical Staff Bylaws.

### **Section 12.4 Credentials Files**

The Medical Staff shall have a policy regarding access to, distribution of, addition to, and disclosure of the content of Medical Staff credentials files that shall be reviewed and approved by the Credentials Committee and Medical Staff Executive Committee as needed (Ref Medical Staff Policy 101: Confidentiality of Records).

## **ARTICLE 13 ADOPTION AND AMENDMENT OF BYLAWS, RULES AND REGULATIONS, POLICIES AND PROCEDURES**

The Medical Staff shall have the responsibility to formulate, review, and recommend to the Governing Body medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Such rules and regulations, policies and procedures, shall be limited to procedural details and processes implementing these Bylaws. The Medical Staff exercises this responsibility through its elected and appointed leaders or through direct vote of its voting membership. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner.

### **Section 13.1 Bylaws**

**13.1.1** Amendments to these Bylaws may be originated by the Medical Staff Executive Committee or by a petition signed by twenty-five percent (25%) of the voting members of the Medical Staff.

- (a) When proposed by the Medical Staff Executive Committee, there will be communication of the amendment to the Medical Staff at least 30 days before a vote is taken by the Medical Staff. The notice shall include the exact wording of the existing Bylaw language, if any, and the proposed change(s).
- (b) When proposed by the Medical Staff, there will be communication of the amendment to the Medical Staff Executive Committee at least 30 days before a vote is taken by the Medical Staff. The notice shall include the exact wording of the existing Bylaw language, if any, and the proposed change(s).

**13.1.2** If the Medical Staff votes to recommend directly to the Governing Body an amendment to the Bylaws that is different from what has been recommended by the Medical Staff Executive Committee, the Conflict Resolution process in Section 13.7 shall be followed within 30 days of the vote.

### **Section 13.2 Non-substantive Changes/Technical Corrections/Clarifications**

The Medical Staff Executive Committee shall have authority to adopt non-substantive changes/technical corrections/clarifications needed to the Bylaws, Rules and Regulations, and

Policies. Such changes shall not affect the intent of the sections being changed. After approval by the Medical Staff Executive Committee, such changes shall be communicated promptly in writing to the Governing Body. Such changes are subject to approval by the Governing Body, which approval shall not be withheld unreasonably. Following approval by the Governing Body, the changes will be communicated to the Medical Staff within a time that is reasonable under the circumstances (which may be when the Medical Staff is notified of the next substantive change to the Bylaws, Rules and Regulations, or Policies affected).

### **Section 13.3 Action on Bylaw Amendment**

A Bylaws amendment shall require an affirmative vote of the majority of the voting members by electronic ballot.

### **Section 13.4 Approval**

Bylaw amendments adopted by the Medical Staff shall become effective following approval by the Governing Body acting on behalf of The Regents, which approval shall not be withheld unreasonably. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff. The matter may be referred to the conflict management process set forth in UCLA Health Policy HS 0343 for management of conflicts between the Governing Body and the Medical Staff.

### **Section 13.5 Effect of the Bylaws**

**13.5.1** These Bylaws may not be unilaterally amended or repealed by the Medical Staff or Governing Body.

**13.5.2** In the event of a conflict between the Medical Staff Bylaws, on the one hand, and the Rules and Regulations and/or Policies and Procedures, on the other, the Bylaws shall prevail.

### **Section 13.6 Rules and Regulations, Policies and Procedures**

#### **13.6.1 Provisional Revisions by the Medical Staff Executive Committee**

The Medical Staff Executive Committee may adopt provisional revisions to Rules and Regulations, Policies and Procedures, that, in the Medical Staff Executive Committee's judgment, are necessary for patient safety, legal, or regulatory compliance. After adoption, these provisional revisions will be communicated to the Medical Staff for its review and opportunity for comments within 7 days of the date of the notice. The revisions will become final at the end of the comment period unless at least twenty-five percent (25%) of voting members express opposition to the revisions in writing.

- (a) If the Medical Staff approves of the provisional revisions, the revisions will stand.
- (b) If the Medical Staff does not approve of the provisional revisions, it will be resolved using the Conflict Resolution process noted in Section 13.7.

#### **13.6.2 Revisions Originating from the Medical Staff**

Revisions to the Rules and Regulations, Policies and Procedures, may be originated by a petition signed by twenty-five percent (25%) of the voting Medical Staff.

- (a) There will be communication of the revisions to the Medical Staff Executive Committee at least 30 days prior to its next scheduled meeting. The submission shall include the exact wording of the existing language, if any, and the proposed change(s).
- (b) If the Medical Staff Executive Committee approves of the revisions, the Medical Staff Executive Committee will forward them to the Governing Body.
- (c) If the Medical Staff Executive Committee does not approve of the revisions, the Medical Staff Executive Committee will implement the Conflict Resolution process in Section 13.7

### **13.6.3 New Policies and Procedures Originating from the Medical Staff Executive Committee**

When the Medical Staff Executive Committee proposes a new policy, there will be communication to the Medical Staff for its review and opportunity for comment within 7 days of the date of the notice. The policy will become final at the end of the comment period unless at least twenty-five percent (25%) of voting members express opposition to the policy in writing.

If the Medical Staff disagrees with a policy proposed by the Medical Staff Executive Committee, it can utilize the Conflict Resolution process noted in Section 13.7.

### **13.6.4 New Policies and Procedures Originating from the Medical Staff**

Medical Staff Policies and Procedures may be originated by a petition signed by twenty-five percent (25%) of the voting Medical Staff.

- (a) There will be communication of the policy to the Medical Staff Executive Committee at least 7 days prior to its next scheduled meeting.
- (b) If the Medical Staff Executive Committee approves of the policy, the Medical Staff Executive Committee will forward it to the Governing Body.
- (c) If the Medical Staff Executive Committee does not approve of the policy, the Medical Staff Executive Committee will implement the Conflict Resolution process in Section 13.7.

## **Section 13.7 Conflict Resolution**

**13.7.1** The Medical Staff Executive Committee shall review the differing recommendations and recommend language to the Bylaws, Rules and Regulations, or Policy that is agreeable to both the Medical Staff and the Medical Staff Executive Committee.

**13.7.2** The Medical Staff shall still have the opportunity to recommend directly to the Governing Body alternative language. If the Governing Body receives differing recommendations from the Medical Staff Executive Committee and the Medical Staff, the Governing Body shall study the basis of the differing recommendations and take action.

