2020-04-29 Regular Meeting of the Truckee Surgery Center Board of Managers

Wednesday, April 29, 2020 at 12:30pm

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, a Regular Meeting of the Truckee Surgery Center Board of Managers for April 29, 2020 will be conducted telephonically through Zoom.

Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting.

Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

2020-04-29 Regular Meeting of the Truckee Surgery Center Board of Managers

04/29/2020 Regular TSC Board of Managers Meeting

AGENDA

TRUCKEE SURGERY CENTER
REGULAR MEETING OF THE BOARD OF MANAGERS

AGENDA

Wednesday, April 29, 2020 at 12:30 p.m.

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If you would like to speak on an agenda item, you can access the meeting remotely:
Please use this web link: https://tfhd.zoom.us/j/92660694709

Or join by phone:
If you prefer to use your phone, you may call in using the numbers below.
(346) 248 7799 or (301) 715 8592
Meeting ID: 926 6069 4709

Public comment will also be accepted by email to mrochefort@tfhd.com. Please list the item number you wish to comment on and submit your written comments 24 hours prior to the start of the meeting.

Oral public comments will be subject to the three minute time limitation (approximately 350 words). Written comments will be distributed to the board prior to the meeting but not read at the meeting.

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT – AUDIENCE**
   This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. **CLOSED SESSION**
   - **5.1. Approval of Closed Session Minutes**◈
     04/01/2020
   - **5.2. Hearing (Health & Safety Code § 32155)**
     Subject Matter: First Quarter 2020 Infection Control Data Summary
     Number of items: One (1)
   - **5.3. Hearing (Health & Safety Code § 32155)**
     Subject Matter: First Quarter 2020 Quality Assessment Performance Improvement Data

◈ Denotes Action Item

Number of items: Four (4)

5.4. Hearing (Health & Safety Code § 32155)◈

Subject Matter: Quality Assessment/Performance Improvement Project Report
Number of items: One (1)

6. APPROVAL OF MINUTES OF: 04/01/2020◈ ..... ATTACHMENT

7. ITEMS FOR BOARD ACTION◈

7.1. Appointments◈

Truckee Surgery Center Board of Managers will appoint the following position: QAPI/IC RN

7.2. Quality Committee◈

Truckee Surgery Center Board of Managers will create a Quality Committee, appoint members, and determine meeting frequency.

7.3. Policy Review◈

Truckee Surgery Center Board of Managers will review and consider approval of the following:

7.3.1. Quality Assessment Performance Improvement (QAPI) Plan, QA-2002..... ATTACHMENT
7.3.2. Medical Staff Bylaws..... ATTACHMENT
7.3.3. Medical Staff Rules and Regulations ..... ATTACHMENT
7.3.4. Delineated Clinical Privilege Request Form - Podiatry..... ATTACHMENT
7.3.5. Delineated Clinical Privilege Request Form - Dentistry..... ATTACHMENT

8. ITEMS FOR BOARD DISCUSSION

8.1. Financial Reports

Truckee Surgery Center Board of Managers will review the following financial report:

8.1.1. Q1 2020 Medbridge Report..... ATTACHMENT

8.2. Facility/Equipment Update

Truckee Surgery Center Board of Managers will receive an update on facility and equipment needs.

9. ITEMS FOR NEXT MEETING

10. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TRUCKEE SURGERY CENTER
SPECIAL MEETING OF THE BOARD OF MANAGERS

DRAFT MINUTES

Wednesday, April 1, 2020 at 1:00 p.m.

Due to COVID-19 shelter in place orders and under the authority of the Governor's Executive Order N-29-20, this meeting will be conducted entirely by teleconference. No physical location was available.

1. CALL TO ORDER

Meeting was called to order at 1:00 p.m.

2. ROLL CALL

Board of Managers: Harry Weis, Crystal Betts, Judy Newland, Dr. Jeffrey Dodd

Staff in attendance: Courtney Leslie, Karla Weeks, Martina Rochefort

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT – AUDIENCE

No public comment was received.

Judy Newland departed the meeting at 1:01 p.m.

5. APPROVAL OF MINUTES OF: 03/09/2020

ACTION: **Motion made by Dr. Dodd, seconded by Betts, to approve the Truckee Surgery Center Minutes of March 9, 2020 as presented. Roll call vote taken.**
Weis - AYE
Betts - AYE
Dodd - AYE

Open Session recessed at 1:03 p.m.

6. CLOSED SESSION

6.1. Approval of Closed Session Minutes

03/09/2020

Discussion was held on a privileged item.

6.2. Hearing (Health & Safety Code § 32155)

Subject Matter: Medical Staff Credentials Report

Discussion was held on a privileged item.

Open Session reconvened at 1:06 p.m.

7. ITEMS FOR NEXT MEETING

-Edits to Bylaws for next meeting.

8. ADJOURN

Meeting adjourned at 1:07 p.m.

Origination:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*1 year after approval*
Owner:	*Courtney Leslie: Manager*
Department:	*Quality and Patient Safety*
Applicabilities:	*Truckee Surgery Center*

Quality Assessment & Performance Improvement (QAPI) Plan, QA-2002

PURPOSE:

A. To provide a framework for promoting and sustaining performance improvement at Truckee Surgery Center (TSC), in order to improve the quality of care and enhance organizational performance. The goals are to pro-actively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our patients and customers. This will be accomplished through the support and involvement of the Truckee Surgery Center (TSC) Governing Body, Medical Director, Administration, Medical Staff, Employees, and Tahoe Forest Hospital District's Quality/Infection Control Department leaders, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and High Reliability tenets to promote and improve awareness of patient safety.

B. To utilize the Plan-Do-Check-Act Cycle or other established QAPI methodology as the standard in our QAPI Program, in order to enhance patient safety and quality of care, and deliver cost effective services.

C. To use an ongoing, data-driven system-wide QAPI Plan that will serve TSC and its patients long into the future.

PROGRAM SCOPE:

A. The program is system-wide. It focuses on high risk, high frequency and/or known problem-prone and safety issues first. It includes but is not limited to the following:

1. Governance Issues
2. Surgical and Medical Services
3. Anesthesia Services
4. Pharmaceutical Services
5. Nursing Services
6. Environment & Safety
7. Medical Records

8. Medical Staff Performance, clinical and other
9. Allied Health Practitioners Performance, clinical and other
10. Laboratory & Radiological Services
11. Radiation Safety
12. Infection Control
13. Patients' Rights
14. Contracted Services
15. Regulatory Compliance

B. The program includes, but is not limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.

C. Truckee Surgery Center will:

1. Measure, analyze, and track specifically designated quality indicators for each of the above service areas.
2. Adverse patient events of all types will be measured, analyzed, and the lessons learned will be established as quality indicators (QI) and will be measured, analyzed, and tracked.
3. Infections and parameters (indicators) for infection control will be established, measured, analyzed, and tracked over time.
4. Other indicators of the care and services furnished in TSC will be established, measured, analyzed, and tracked as above.

PROGRAM DATA:

A. Truckee Surgery Center's QAPI Program incorporates quality indicator data, including patient care and other relevant data regarding services furnished at TSC. The goal is 100% compliance with each identified quality metric. TSC uses the data collected for:

1. Monitor the effectiveness and safety of services and quality of care.
2. Identify opportunities that could lead to improvements and changes in its patient care.

B. Data includes:

1. Procedures Provided at TSC:
    a. Surgical/invasive and manipulative procedures
    b. Pain management procedures
2. Radiological Services:
    a. Radiation safety screening results
        i. Badge reports
    b. Radiation equipment monitoring
        i. Phantom tests/Jug tests
        ii. Physicist checks

iii. Lead shield integrity

iv. Quarterly fluoroscopy monitoring

3. Infection Control:
    a. Hand hygiene surveillance
    b. Surgical attire surveillance
    c. Safe Injection Practices
    d. Infection control in the operating rooms
    e. Sterile processing surveillance
    f. Environmental cleaning surveillance
    g. Monitoring of immediate use sterilization
    h. Surgical Site Infections (SSI's)
    i. Timing of prophylactic antibiotic administration
4. Adverse Events:
    a. Unplanned hospital transfer/admission
    b. Adverse event including wrong site, side, patient, or implant
    c. Medical errors including medication, surgical, and diagnostic errors; equipment failures, blood transfusion related injuries, and deaths due to seclusion or restraints
5. Pharmacy:
    a. Medication therapy
    b. Medication errors
    c. Adverse drug reactions
    d. Formulary
    e. Quarterly chart reviews
6. Environment of care:
    a. Fire & Disaster Preparedness
    b. Monitoring of temperature and humidity in OR's, preop/PACU, and sterile storage
    c. Refrigerator temperature monitoring
    d. Blanket warmer temperature monitoring
    e. Daily/Quarterly cleaning logs
7. Medical Staff:
    a. Credentialing
    b. Peer Review
8. Nursing Services:
    a. Nursing chart review
    b. Annual competencies

c. Safe surgery checklist

9. Patient Safety & Care:
    a. Resuscitation and critical incidents, including debriefings
    b. Clinical record reviews, surgery and pain
    c. Patient stay surveillance
    d. Nausea and vomiting surveillance, in PACU and after discharge
    e. Patient Satisfaction Survey surveillance
    f. Monthly data collection
        i. Anesthesia complications
            a. Slow to Awaken surveillance
            b. Discharge delays
        ii. Delay of cases
        iii. Antibiotic administration time
    g. Complaints and grievances

PERFORMANCE IMPROVEMENT INITIATIVES:

A. TSC has prioritized its 2020 Performance Improvement initiatives with the goals of meeting and exceeding the national benchmark standards of the Ambulatory Surgery Center Organization (ASCA):
    1. Improving the rate of reported surgical site infections (SSIs)
    2. Improving the rate of transfers to a higher level of care
    3. Evolving the process of antibiotic administration
    4. Improving the pre-surgical nerve block and time-out processes

    TSC's designated initiatives were also prioritized with the intention of survey readiness, and compliance with federal and state regulations, to result in the successful initial Healthcare Facilities Accreditation Program (HFAP) survey.

B. Priorities identified include:
    1. Exceed national benchmark standard of reported surgical site infections (SSIs)
        a. Utilize the Plan-Do-Check-Act method to obtain, measure, analyze, and track prior data, with the goal of promoting and guiding new and continued policies and procedures in the prevention of infections.
        b. Continue to implement and monitor infection control and quality indicators.
    2. Exceed national benchmark standard of transfers to higher level of care
        a. Implement new and improved patient safety protocols, with special attention to pre-admission health history screening.
        b. Utilize the Plan,-Do-Check-Act method to obtain, measure, analyze, and track data, with the goal of promoting and guiding new and continued policies and procedures in maintaining patient safety.
    3. Focus on promoting best-practice and evidence-based medicine, particularly with prophylactic

antibiotic administration

a. Collaborate with TSC's Medical Director, Medical Staff, and nursing staff to promote improved policies and procedure(s) in the timing of administered antibiotics.

4. Perform the safest possible patient care, with particular focus on pre-surgical nerve blocks

a. Implement necessary Process Improvement interventions to **maintain the safety of every patient**, **every time**.

b. Focus on building a competent, organized team in the process of sustaining patient safety, with particular attention to surgical and nerve block time-outs.

C. TSC's priority QAPI activities will:

1. Focus on high risk, high volume, and problem-prone issues,
2. Consider incidence, prevalence, and severity of any noted problem areas,
3. Place our healthcare outcomes, patient safety and the overall quality of our care as high priority.

D. Decisions to improve TSC's processes are based on the following:

1. TSC's mission and goals
2. A change in the facility's Scope of Services
3. An undesirable change occurs, such as an Adverse or Unanticipated Patient Care Outcome, Sentinel Event or Near Miss
4. An issue defined and/or determined by the Performance Improvement process
5. It is part of an important function as defined by a regulatory health care body such as the Department of Health Services, Medicare, an accrediting agency such as the Joint Commission or Heathcare Facilities Accreditation Program (HFAP), or is an accepted community health care standard.

E. Our program will track all known adverse patient events, and a Root Cause Analysis (RCA) will be performed for each event. The initial plan will use cause and effect diagrams and flow diagrams for the RCA. As the plan progresses, other formats will be explored and when the long-term plan is developed other RCA methodology could be developed.

F. Truckee Surgery Center will utilize baseline data and aggregated data to determine the following quality of care goals:

1. Improving existing processes
2. Developing new processes
3. Development of action plans for improvement
4. New goals for improvements of past processes that have not been maintained
5. Comparisons with internal and external quality benchmarks
6. Determining whether Risk Management/Patient Safety issues are being addressed and evaluated appropriately

G. The lessons learned from any RCA will be used to design Performance Improvement (PI). The PI methodology will utilize the Deming Cycle of Plan-Do-Check-Act (PDCA) to test and refine our implementation of improvement.

H. Improved performance derived by these PI activities will be monitored over time utilizing repeated PDCA analysis to ensure that our improved performance will be sustained over time.

I. Periodically (at least annually) the medical staff and nursing staff at TSC will be provided specific QAPI training about PI methodology and TSC's evolving improvement strategies derived for our QAPI program. The goal is to ensure that all staff is familiar with these strategies.

J. Recent focus of our QAPI Program has been placed on opportunities for improvement including the following:

1. Radiological Services:
    a. Radiation Safety Screening is performed by an outside vendor. The exposure time is validated and a report is provided quarterly. The Radiation Safety Officer audits and reviews the reports for any outliers and reports any issues to the Administrator. The facility works cooperatively with the Radiology department of Tahoe Forest Hospital who provides additional review as needed and documents any findings.
    b. Phantom/Jug Tests are performed weekly by the Radiology department of Tahoe Forest Hospital. These results are input into a formula to determine outliers; any abnormal results are reported to the Administrator and documented in the fluoroscopy binder.
    c. TSC's contracted physicist provides an annual check of all radiological equipment in the facility for safety and effectiveness. A report is produced and is reviewed by the Radiology department of Tahoe Forest Hospital, Medical Executive and Quality Committee, Governing Body, and Administrator.
    d. Lead Shield Integrity is evaluated annually by performing x-ray on the lead equipment and observing the images for gaps in protection. The evaluation is performed by the Radiology department of Tahoe Forest Hospital. Results are reported to the Medical Executive Quality Committee, Governing Body, and Administrator.
2. Infection Control:
    a. Unannounced hand hygiene and surgical attire surveillances are performed monthly by the QAPI/IP Coordinator using the audit tools.
    b. The Sterile Processor will perform monthly audits of all Immediate Use Sterilization and will provide a report on this information to the QAPI/IP Coordinator.
    c. Surgical Site Infection data is obtained from the physicians via a monthly memorandum. The reports are provided to the QAPI/IP Coordinator and reported to the Quality Committee, Medical Executive Committee, and Governing Board.
3. Adverse Events:
    a. Hospital Transfers/Admissions are documented on Occurrence/Notification Reports by the attending staff and provided to the QAPI/IP Coordinator and Administrator for immediate review.
    b. Adverse Events are documented on an Occurrence/Notifiation Report by the attending staff and provided to the QAPI/IP Coordinator and Administrator for immediate review.
4. Pharmacy:
    a. Medication Errors are documented on the Surgical Log as well as in an Occurrence/Notification Report by the attending staff and provided to the QAPI/IP Coordinator and Administrator for immediate review.
    b. Adverse Drug Reactions are documented on the Surgical Log as well as in an Occurrence/ Notification Report by the attending staff and provided to the QAPI/IP Coordinator and

Administrator for immediate review.

c. A formulary has been created by the nursing staff in cooperation with the contracted Pharmacist. The formulary will be updated as necessary and reviewed and approved by the MEC/Governing Board annually.

5. Environment of Care:

a. The Fire and Disaster Preparedness Plans have been reviewed with the facility staff, Medical staff and the MEC and Governing Board. Quarterly Fire Drills are performed with written evaluation including areas for improvement. Annual Disaster Preparedness Drills will be performed with written evaluation including areas for improvement.

b. Temperature and Humidity logs are maintained by the nursing staff. Any values outside of acceptable parameters will be reported to the Administrator immediately for documentation and corrective action.

6. Medical Staff:

a. Credentialing will be performed biennially per facility policy and Medical Staff Bylaws. The credential file will be reviewed by the Medical Director and then reviewed and approved by the MEC & Governing Board.

b. Peer Review will be performed quarterly by all practitioners at the facility. Peer review will be performed per facility policy.

7. Nursing Services:

a. Nursing Chart Reviews will be performed quarterly by a designated nurse. Documentation and nursing care will be evaluated. The nursing chart review form will be completed and submitted to the QAPI/IP Coordinator & Administrator. Trends are analyzed and opportunities for improvement are discussed with staff. Special Instructions / Definitions:

b. Annual competencies, per facility policy, will be evaluated by the Nursing supervisor and Administrator.

K. A Safe Surgery Checklist is performed by the medical and/or nursing staff prior to each surgery to ensure that all personnel are introduced, confirmation of the correct patient is made, allergies discussed, procedure confirmed, the site is marked, and the patient is positioned correctly. There is confirmation that the surgeon and anesthesiologists needs for equipment are med and readily available, that pre-op antibiotics have been administered within 60 minutes prior to surgical cut time, and that fluoroscopy badges are worn by all personnel (when applicable). At the conclusion of the surgery, there is verbal communication of **correct** counts, name of the procedure, and specimen label(s) (when applicable), and the physician and anesthesiologist are then asked to state any recovery or equipment concerns. This checklist becomes a permanent part of the patient's record.

CLINICAL PRACTICE GUIDELINES:

A. A Clinical Practice Guideline (CPG) is used to design or to improve process(es) that evaluate/treat specific diagnosis, condition, symptoms, or procedure. Clinical practice guidelines help practitioners and patients make decision about preventing, diagnosing, treating, and managing selected conditions. These guidelines can also be used in designing clinical processes or in checking the design of existing processes. TSC identifies criteria that guide the selection and implementation of clinical practice guidelines which are consistent with its mission and priorities.

B. The following steps will be completed in the development of clinical practice guidelines:

1. The Quality Committee and TSC leadership will discuss the most likely processes, procedures or diagnoses to be reviewed based on TSC's Scope of Services and approved procedure list. A high volume, high risk or problem prone process will be selected when needed.
2. Clinical practice guidelines for the chosen project will be reviewed via the Internet using multiple sources. Sources of clinical practice guidelines include the Agency for Healthcare Research and Quality, the National Guideline Clearinghouse (www.ihi.org), and professional organizations in an effort to provide current Evidence Based Practice (EBP) guidelines in effect within healthcare specialties.
3. An appropriate team will be formed to assist with the development of the CPG. The team will follow the Plan-Do-Check-Act process for development of the CPG.
4. The CPG project may be identified by clinical staff within TSC based on risk factors or difficult processes currently part of the healthcare delivery system.
5. Variation in practice with regards to the Clinical Practice Guideline will be tracked by the facility and significant variances and/or adverse patient outcomes will be communicated to the Medical Executive Committee and Governing Board.
6. Variations in practice from the suggested CPG parameters does not necessarily mean potential negative outcomes are imminent, but should be used to re-evaluate the parameters of the CPG in use within the facility.

ORGANIZATIONAL FRAMEWORK:

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all departments, services, and external partners, including third-party payors and other physician groups. Though the responsibilities of this plan are delineated according to common groups, it is recognized that true process improvement outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

Governing Body

A. The Governing Body has the ultimate responsibility for the quality of care and services provided at Truckee Surgery Center. The Governing Body assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Surgery Center activities.

B. The Board:

1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
2. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
3. Provides direction for the organization's improvement activities through the development of strategic initiatives;
4. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Quality Committee, and Medical Staff.

Quality Committee

The Quality Committee is to provide oversight for Truckee Surgery Center's QAPI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treat and services to ensure that it is safe, timely, effective, efficient, equitable, and patient-centered. They will oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

A. The Medical Executive Committee (MEC) shares responsibility with the Quality Committee for the ongoing quality of care and services provided within Truckee Surgery Center.

B. The MEC provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

C. The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided through Truckee Surgery Center to the Quality Committee. QAPI reports are provided quarterly to assess TSC's plan.

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.

B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

Quality Assurance/Performance Improvement/Infection Prevention Coordinator (QAPI/IP)

The QAPI/IP Coordinator creates a vision and direction for clinical quality and patient safety throughout Truckee Surgery Center. The QAPI/IP Coordinator, in conjunction with the Administrator, nursing Supervisor, Medical Director, Medical Staff, and TSC employees, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to TSC patients. The QAPI/IP Coordinator communicates patient safety, best practices, and process improvement activities to the Administrator, Nursing Supervisor, Medical Director, Medical Staff, TSC staff, and engages them in improvement activities.

TSC Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative.

Quality is everyone's responsibility and each employee is charged with practicing and supporting TSC's plan.

B. Employees are expected to do the following:

1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and families;
2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team; including risk reduction recommendations and suggestions for improving patient safety, by contacting the QAPI/IP Coordinator and/or Administrator. All employees must feel empowered to report, correct, and prevent problems.

BENCHMARKING:

Measurement is the foundation of all Performance Improvement activities. Measurement involves the collection of data and forms the basis for determining the level of performance of existing processes and functions within Truckee Surgery Center, and the outcomes resulting from these processes and functions.

A. INTERNAL BENCHMARKING:

1. The measurement system includes data on:
   a. Outcomes both directly and indirectly related to patient care
   b. A comprehensive set of Quality Indicators, including not limited to, the ASC Divison Quality Indicators which track both the quality and quantity of those designated patient care areas
   c. Risk Management issues and occurrences, inclusive of Sentinel/Adverse Events
   d. Patient satisfaction surveys and Patient complaints/grievances
   e. Human Resource and staff learning needs identified
   f. The Environment of Care safety - Fire and Disaster plans

B. EXTERNAL BENCHMARKING:

1. External benchmarking for other patient care issues and activities may include, but is not limited to:
   a. American Society of Anesthesiologists
   b. American College of Surgeons
   c. American Academy of Orthopedic Surgeons
   d. National Association of Orthopedic Nurses
   e. American Association of Peri anesthesia Nurses
   f. Associate of Perioperative Nurses, etc.
   g. Clinical Practice Guidelines, published at a National Guideline Clearinghouse
   h. Center for Disease Control
   i. Association for Professionals in Infection Control (APIC)
   j. Recognized practice guidelines relevant to a community standard of care

PERFORMANCE IMPROVEMENT:

Education

A. Training and education are essential to promote a culture of quality within Truckee Surgery Center. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.

B. The QAPI/IP Coordinator, Nursing Supervisor and/or Administrator will provide education to all staff members on the QAPI Plan and their role in performance improvement activities.

Priorities

A. The QAPI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

B. Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solutions affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Truckee Surgery Center. During planning, the following are given consideration:

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect health outcomes, patient safety, and quality of care
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
5. Processes related to patient flow
6. Processes associated with Near Miss, Sentinel/Adverse Event/Error or Unanticipated Outcome

C. Because TSC is sensitive to the ever changing needs of its facility, priorities may be changed or re-prioritized due to:

1. Identified needs from data collection and analysis
2. Unanticipated adverse occurrences affecting patients
3. Processes identified as error prone or high risk regarding patient safety
4. Processes identified by proactive risk assessment
5. Changing regulatory requirements
6. Significant needs of patients and/or staff
7. Changes in the environment of care
8. Changes in the community

Project

A. The Performance Improvement (PI) Projects at Truckee Surgery Center reflect the scopy and complexity

of the facility's services and operations, and are based off of noted areas for improvement from practice.

B. The Deming Cycle:
    1. TSC uses thePlan-Do-Check-Act (PDCA) Cycle to evaluate, plan, design, and implement processes to improve within the surgery center.
    2. PLAN:
        a. Project Start-Up
            i. Decide the focus of improvement or issue to be improved
            ii. Confirm the aim of the project
        b. Current Situation - identify and collect baseline data
            i. Confirm that problem exists with data
            ii. Analyze your current process
            iii. Develop a measurable goal for the project
        c. Perform Cause Analysis
            i. Evaluate the following:
                a. Resources
                b. Equipment
                c. People
                d. Methods
    3. DO:
        a. Develop and implement solutions
            i. Perform a pilot/trial run on a small scale or time frame
            ii. New solutions may require that the DO step is repeated
    4. CHECK:
        a. Analyze the effect of solutions implemented
            i. Compare with baseline data and goal of the project
            ii. Has improvement been gained?
            iii. Has the goal been met?
            iv. Standardize the successful solutions
        b. Adopy, adapt for alter solutions
            i. Repeat the DO and CHECK processes for failed solutions
    5. ACT:
        a. Standardization
            i. Fully implement the solutions by defining the new process and the methods for communicating, training and maintaining the goal of the project
        b. Future Plans
            i. Evaluate what was learned from the project

ii. Continue the project if the goal was not met

iii. Develop new solutions and checks as needed

AGGREGATION AND ANALYSIS OF DATA:

A. In addition to the Program Data listed above, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:

1. Quality Measures delineated in clinical contracts will be reviewed annually
2. Summaries of performance improvement actions and actions to reduce risks to patients
3. Pharmacy transactions as required by law and to control and account for all drugs
4. Information about hazards and safety practices used to identify safety management issues to be addressed by TSC
5. Reports of required reporting to federal and state authorities
6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

B. These data are reviewed regularly by the Medical Executive Quality Committee and Governing Body with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

C. Truckee Surgery Center believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data, and are in compliance with the Tahoe Forest Health System plan. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within TSC, within the Tahoe Forest Health System, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes which will help improve patient safety and promote a perfect care experience.

D. The data used to monitor the effectiveness and safety of services and quality of care. The data analysis identifies opportunities for process improvement and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.

E. Data is analyzed in many ways including:

1. Using appropriate performance improvement problem solving tools
2. Making internal comparisons of the performance of processes and outcomes over time
3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals and reference databases

F. Intensive analysis is completed for:

1. Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
2. Significant and undesirable performance variations from recognized standards
3. A sentinel event which has occurred (see policy Sentinel/Adverse Event/Error or Unanticipated Outcome, QA-2001)

4. Variations which have occurred in the performance of processes that affect patient safety
5. Hazardous conditions which would place patients at risk
6. The occurrence of an undesirable variation which changes priorities

G. The following events will automatically result in intense analysis:

1. Significant confirmed transfusion reactions
2. Significant adverse drug reactions
3. Significant medication errors
4. All major discrepancies between preoperative and postoperative diagnosis
5. Adverse events or patterns related to the use of sedation or anesthesia
6. Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
7. Staffing effectiveness issues
8. Deaths associated with a hospital acquired infection
9. Core measure data, that over two or more consecutive quarters for the same measure, identify TSC as a negative outlier

REPORTING:

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services will be reported to the Medical Executive Quality Committee quarterly.

B. TSC also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in external quality reporting initiatives.

CONFIDENTIALITY AND CONFLICT OF INTEREST:

All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any TSC employee or Medical Staff in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure.

Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved unless specifically requested to participate in the review. All information related to performance improvement activities performed in accordance with this plan is confidential and are protected by disclosure and discoverability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT:

The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patient served and volume of services), chart review (a representative sample of both active and closed clinical records), and TSC's policies addressing provision of

services.

The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Executive Quality Committee and Governing Body.

Related Policies/Forms:

Infection Control Plan, IC 1914

Occurrence/Notification Reports, QA-1903

Risk Management, QA-1905

Sentinel Event/Error or Unanticipated Outcome, QA-2001

References:

HFAP, the Joint Commission, CMS COPs, HCQC NRS/NAC

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Manager	pending

TRUCKEE SURGERY CENTER, LLC
MEDICAL STAFF BYLAWS

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PREAMBLE

These bylaws create a structure to provide an efficient, democratic framework to Medical Staff of Truckee Surgery Center, LLC (TSC, LLC). The Medical Staff endeavors to improve performance while promoting professional relationships among the members, TSC, LLC staff, patients and the community.

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL or AHP means a health care provider who is licensed or possesses the appropriate legal credentials, and is other than a licensed physician, dentist or podiatrist. AHPs may be granted practice prerogatives within the scope of their license/legal credential on the approval of the MEC and the Governing Board. The AHP shall exercise his/her practice prerogatives under the supervision of a physician, osteopath, podiatrist, or dentist member of the Medical Staff, when required by law, and in conformity with the law and these bylaws. AHPs are not members of the Medical Staff.[PD1][LC2]

2. AUTHORIZED REPRESENTATIVE or SURGERY CENTER'S AUTHORIZED REPRESENTATIVE means the individual designated by the Governing Board and approved by the MEC to provide information to and request information from the National Practitioner Data Bank.

3. CENTER REPRESENTATIVE means a person appointed by the MEC to deliver and receive notices and any other information, or act on behalf of the Governing Board in connection with any hearing conducted pursuant to Article VII hereof.

4. CLINICAL PRIVILEGES or PRACTICE PREROGATIVES means the authorization granted by the Governing Board to a practitioner or an AHP to provide specific patient care services at the Surgery Center within defined limits, based on an individual's or AHP's license or other legal credential, education, training, experience, competence, health status and judgment.

5. CVO means an external Credentialing Verification Organization (CVO)

6. GOVERNING BOARD means the Board of Managers of TSC, LLC, as defined in the Operating Agreement of TSC, LLC.

7. INVESTIGATION means a formal appointment of a committee or a process formally initiated by a MEC when acting as a peer review body. The MEC may also appoint committees for purposes other than a formal "investigation," such as to "evaluate" a situation or a practitioner. Such evaluation shall not constitute an "investigation," for purposes of reporting obligations under **[either]** California Business and Professions Code Section 805 or the Health Care Quality Improvement Act and the National Practitioner Data Bank (NPDB).[PD3][PD4]

8. MEDICAL DISCIPLINARY CAUSE OR REASON OR MDCR means that aspect of an applicant's or member's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

9. MEDICAL EXECUTIVE COMMITTEE or MEC means the Executive Committee of TSC, LLC responsible for governing the Medical Staff as described in these bylaws.

10. MEDICAL STAFF or STAFF means those M.D.s, D.O.s, Dentists, or Podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these bylaws.

11. MEDICAL STAFF YEAR means the period from January 1 to December 31.

12. PRACTITIONER means an individual who holds a current license as an M.D., D.O. or D.P.M. by the State of California.

13. SURGERY CENTER means surgery center owned and operated by TSC, LLC.

ARTICLE I. NAME, PURPOSES AND RESPONSIBILITIES[PD5]

1.1 NAME

The name of this organization is the Medical Staff of TSC, LLC.

1.2 PURPOSES OF THE MEDICAL STAFF

The purposes of the Medical Staff are to:

1.2.1 be the formal organizational structure through which (1) the benefits of membership on the Medical Staff may be obtained by individual practitioners and (2) the obligations of Medical Staff membership may be fulfilled.

1.2.2 serve as the primary means for accountability to the Governing Board for the appropriateness of the professional performance and ethical conduct of its members and AHPs.

1.2.3 strive toward the continual upgrading of the quality and safety of patient care delivered at the Surgery Center.

1.2.4 provide a means through which the Medical Staff may participate in TSC, LLC's policy-making.

1.3 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff are to:

1.3.1. account to the Governing Board for the quality of patient care provided by all Medical Staff members and by all AHPs authorized pursuant to the

bylaws to practice at TSC, LLC through regular reports and recommendations concerning the implementation, operation and results of the quality review and evaluation activities, which shall be developed through the following means:

(a) Review and evaluation of the quality of patient care through a valid and reliable patient care assessment procedure.

(b) An organizational structure and mechanisms that allow concurrent monitoring of safe patient care and clinical practices.

(c) A credentials program, including mechanisms for appointment and reappointment and the granting of clinical privileges to be exercised or practice prerogatives to be performed with the verified credentials and current demonstrated performance of the applicant, Medical Staff member or AHP. Quality management information shall be included in the appraisals.

(d) Cooperation with nursing staff in development of policies relating to patient care.

1.3.2. recommend to the Governing Board action with respect to appointments, reappointments, Medical Staff category, clinical privileges, practice prerogatives and corrective action.

1.3.3 recommend to the Governing Board programs for the establishment, maintenance, continuing improvement and enforcement of a high level of professional standards in the delivery of health care at the Surgery Center.

1.3.4 account to the Governing Board for the quality of patient care through regular reports and recommendations concerning the implementation, operation and results of the quality review and evaluation activities.

1.3.5. initiate and pursue corrective action with respect to practitioners and AHPs, when warranted.

1.3.6. develop, administer, and recommend amendments to and seek compliance with these bylaws, the Medical Staff rules and regulations, and TSC, LLC policies.

ARTICLE II. MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff of TSC, LLC is a privilege which shall be extended only to individuals holding degrees in medicine, osteopathy, dentistry or podiatry who continuously meet the qualifications, standards and requirements set forth in these bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2.1 GENERAL QUALIFICATIONS

Only physicians, doctors of osteopathy, dentists, and podiatrists who:

(a) Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) Are determined to (1) strictly adhere to the Code of Ethics of both the surgery center and the American Medical Association, American Dental Association, American Podiatry Association, or American Osteopathic Association, whichever is applicable, as well as this Medical Staff's Bylaws and Rules and Regulations and applicable policies of the Medical Staff and the Center, [PD6](2) be able to work cooperatively with others so as not to adversely affect patient care, (3) keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) be willing to participate in and properly discharge those responsibilities determined by the Medical Staff;

(c) Maintain in force professional liability insurance in not less than One Million Dollars ($1,000,000) per occurrence and Three Million ($3,000,000) in the aggregate. The MEC, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis;

(d) Practice within the community within a reasonable distance of the Surgery Center; and

(e) Maintain membership or affiliation in good standing at one of the local accredited acute care hospitals of which a transfer agreement is in place.

shall be deemed to possess basic qualifications for membership on the Medical Staff. If a practitioner does not meet these basic qualifications, he/she will not be provided an application to the TSC, LLC Medical Staff.

2.2.2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician membership on the Medical Staff must hold an M.D. or D.O. degree, and must also

hold a valid and unsuspended license to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California.

(b) Limited License Practitioners:

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

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

2.3 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, religion, ancestry, national origin, disability, medical condition, marital status or sexual orientation, or other considerations not impacting the applicant's ability to discharge the privileges for which s/he has applied or holds, [PD7]if after reasonable accommodation, the applicant complies with the bylaws and Rules and Regulations.

2.4 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The ongoing responsibilities of each Medical Staff member include:

2.4.1 Providing patients with the quality of care meeting the professional standards of the Medical staff of TSC, LLC;

2.4.2 Abiding by the Medical Staff's bylaws and rules and regulations;

2.4.3 Preparing and completing in a timely fashion medical records for all the patients to whom the member provides care in the Surgery Center;

2.4.4 Abiding by the lawful ethical principles of the California Medical Association or member's professional association;

2.4.5 Working cooperatively with other members and staff so as not to adversely affect patient care; and

2,4.6 Refusing to engage in improper inducements for patient referral.

2.4.7 Not deceive a patient as to the identity of any practitioner providing care or service.

2.4.8 Not delegate the responsibility for diagnosis or care of patients to another practitioner who is not qualified to take on this responsibility.

2.4.9 Cooperate in all peer review and quality assurance review of their practice and notify the Medical Director of any corrective action initiated by other healthcare organizations, agencies or professional associations; loss of malpractice coverage and any other change in the information that an applicant for appointment or reappointment must submit.

2.4.10 Refrain from unlawful harassment or discrimination against any person based on the person's age, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation.

ARTICLE III. CATEGORIES OF MEDICAL STAFF MEMBERSHIP AND ALLIED HEALTH PROFESSIONAL STATUS

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, courtesy, provisional and temporary. At each time of reappointment, the member's staff category shall be determined.

3.2 ACTIVE MEDICAL STAFF

3.2.1 QUALIFICATIONS

The Active Medical Staff shall consist of members who:

(a) Meet the general qualifications for membership set forth in Section 2.2; and

(b) Regularly provided care to at least ten (10) patients a year in the Surgery Center.

3.2.2 PREROGATIVES

Except as otherwise provided, the prerogative of an Active Medical Staff member shall be to:

(a) Admit patients and exercise such clinical privileges as are granted pursuant to Article V;

(b) Attend and vote on matters presented at general and special meetings of the Medical Staff and of the committees of which he or she is a member; and

(c) Hold staff office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

3.3 THE COURTESY MEDICAL STAFF

3.3.1 QUALIFICATIONS

The courtesy Medical Staff shall consist of members who:

(a) Meet the general qualifications for membership set forth in Section 2.2;

(b) Regularly care for (or reasonably anticipate regularly caring for) less than ten (10) patients per year in the Surgery Center;

(c) Have satisfactorily completed appointment in the provisional category.

3.3.2 PREROGATIVES

Except as otherwise provided, the courtesy Medical Staff member shall be entitled to;

(a) Admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) Attend in a non-voting capacity meetings of the Medical Staff, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Courtesy staff members shall not be eligible to hold office in the Medical Staff.

3.4 PROVISIONAL STAFF

3.4.1 QUALIFICATIONS

The provisional Medical Staff shall consist of members who meeting the general Medical Staff membership qualifications set forth in Section 2.2.

3.4.2 PREROGATIVES

The provisional Medical Staff member shall be entitled to:

(a) Admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) Attend meetings of the Medical Staff, including committee meetings with the permission of the chairman, and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Provisional Medical Staff members shall not be eligible to hold office in the Medical Staff.

3.4.3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each provisional staff member shall undergo a period of observation by designated monitors as described in Section 5.3. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. The MEC shall establish in rules and regulations the frequency and format of observation the MEC deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained.

3.4.4 TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the provisional staff until ten (10) cases have been reviewed by a physician appointed by the MEC. Five (5) of the ten (10) cases may be completed at a local Medicare-certified hospital as long as written documentation of such is provided by the member.

3.4.5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the provisional staff member has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active or Courtesy Medical Staff as appropriate, on recommendation of the Medical Director to MEC and Governing Board; and

(b) In all other cases, the Medical Director and MEC make its recommendation to the Governing Board regarding a modification or termination of clinical privileges, or termination of Medical Staff membership.

3.5 TEMPORARY STAFF

3.5.1 QUALIFICATIONS

The Temporary Staff shall consist of physicians, dentists, and podiatrists who do not actively practice at the Surgery Center but are important resource individuals for non-clinical Medical Staff quality management activities (i.e. proctoring, peer

review activities, consultation on quality management). Such persons shall be qualified to perform the non-clinical functions for which they are made temporary members of the staff.

3.5.2 PREROGATIVES

Temporary Medical Staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality management functions. They shall have no privileges to perform clinical services in the Surgery Center. They may not admit patients to the ambulatory care center, or hold office in the Medical Staff organization. Finally, they may attend Medical Staff meetings outside of their committees, on invitation.

3.6 ONE-TIME SURGICAL ASSIST PRIVILEGES

Only physician Medical Staff members shall be eligible for one-time surgical assist privileges. The physician must be a member in good standing at a local Medicare-certified hospital. The physician must notify the TSC, LLC authorized representative one week prior to the scheduled procedure. The following documentation must be received: 1) copy of a valid California medical license and DEA certificate, 2) copy of malpractice insurance certificate and, 3) a report of all actions by any licensing or regulatory agency, medical group, or hospital against the physician. Prior to granting the privileges, the Medical Board, the National Practitioner Data Bank, the OIG/GSA exclusion list, and the hospital where the physician holds clinical privileges shall be queried, the answers shall have been received and have been deemed acceptable by the Medical Director. The authorized representative will verify all information and the Medical Director will review and approve/disapprove the privileges. There is no application fee. The privilege will be granted for one day only and may be requested three (3) times in a twelve (12) month period.

3.7 ALLIED HEALTH PROFESSIONALS[PD8]

3.7.1 DEFINITION

Allied Health Professional or AHP means a health care provider who is licensed or possesses the appropriate legal credentials, and is other than a licensed physician, dentist or podiatrist. AHPs may be granted practice prerogatives within the scope of their license/legal credential on the approval of the MEC and the Governing Board. The AHP shall exercise his/her practice prerogatives under the supervision of a physician, osteopath, podiatrist, or dentist member of the Medical Staff, when required by law, and in conformity with the law and these bylaws. AHPs are not members of the Medical Staff.

3.7.2 QUALIFICATIONS

An AHP may be granted practice prerogatives as described in Section 3.7.1 hereof, provided he or she holds a current license or other legal credential as required by State law, and who:

(a) documents his or her experience, background, training, demonstrated ability, physical health status and mental health status, with sufficient adequacy to demonstrate that any patient treated by them shall receive care of the generally recognized professional level of quality and that they are qualified to provide a needed service at the Surgery Center; and

(b) are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable and to work cooperatively with others; and

(c) participates in continuing medical education applicable to their specialty; and

(d) demonstrates acceptable malpractice coverage.

3.7.3 APPLICATIONS

Applications for AHP status and practice prerogatives will be processed in a parallel manner to those for Medical Staff members, as appropriate.

3.7.4 PREROGATIVES

AHPs shall be eligible to provide services at TSC, LLC under this category. The MEC may establish particular qualifications for AHPs.

3.7.5 DURATION

The qualifications of each AHP shall be reviewed on initial application and every two (2) years thereafter.

3.7.6 PROCEDURAL RIGHTS

Nothing herein shall create any vested rights to any such AHP to receive or maintain any practice prerogatives.

Anyone entitled to impose a summary suspension pursuant to Section 6.3 has the authority to summarily suspend an AHP. Termination of AHPs shall not entitle them to any of the hearing and appeal provisions of Article VII, unless otherwise required by law. For AHPs, a hearing with unbiased members of the MEC and an appeal to the Governing Board shall be provided if practice prerogatives have been denied, revoked, or restricted for a Medical Disciplinary Cause or Reason.

In the event that an AHP has acquired AHP status by virtue of his/her employment or other relationship with a member of the Medical Staff, termination shall be automatic and simultaneous on the termination of the relationship between the Medical Staff member and TSC, LLC or the Medical Staff member and the AHP without the right to a hearing or appeal.

3.7.7 CATEGORIES

The Governing Board shall determine, based on comments of the MEC and such other information as it has before it, those categories of AHPs that shall be eligible to exercise clinical privileges or practice prerogatives in the Surgery Center. AHPs exercising practice prerogatives in a Governing Board-approved category shall be subject to supervision requirements as required by law and as recommended by the Allied Health Professionals Committee and the MEC, and approved by the Governing Board.

ARTICLE IV. APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person shall exercise clinical privileges in the Surgery Center unless that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these bylaws.

4.2 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these bylaws, but only after there has been a recommendation from the Medical Director to the MEC and Governing Board.

4.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the Medical Staff shall be for a period of two (2) years. Reappointments shall be for a period of two (2) years.

4.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT[PD9]

4.1.1 APPLICATION FORM

An application form shall be approved by the MEC. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) The applicant's qualifications, including, but not limited to, education, professional training and experience, current licensure, current DEA registration, and continuing medical education

information related to the services to be performed by the applicant;

(b) Peer references familiar with the applicant's professional competence and ethical character;

(c) Request for specified clinical privileges;

(d) Past or pending professional disciplinary action, licensure limitation, or related matter;

(e) Physical and mental health status;

(f) Final judgments or settlements made against the applicant in professional liability cases, and any filed cases pending; and

(g) Professional liability coverage.

(h) Criminal Background Screening

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed or accompanied by an explanation of why answers are unavailable, and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these bylaws, the Medical Staff rules and regulations, and summaries of other applicable policies relating to clinical practice at the Surgery Center, if any.

4.4.2 EFFECT OF APPLICATION

By applying appointment to the Medical Staff each applicant:

(a) Signifies willingness to appear for interviews regarding the application;

(b) Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

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

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

(f) Consents to the disclosure to other organizations, hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that TSC, LLC or the Medical Staff may have, and releases the Medical Staff and Governing Board from liability for so doing to the fullest extent permitted by law; and

(g) Pledges to provide for continuous quality care for patients.

4.4.3 VERIFICATION OF INFORMATION[PD10]

The applicant shall deliver a completed application to the CVO credentialing designee. An application is considered "complete" when all required application information and supporting documents have been received. The Medical Executive Committee or designee shall be notified of the application. The CVO shall seek to collect and primary source verify the references, licensure status, DEA, State DPS, State CDS if applicable, Medical malpractice insurance coverage consistent with guidelines of the Governing Body, Criminal background check, board certification, and other evidence submitted in support of the application, as indicated in the credentialing policies and procedures[PD11]. TSC, LLC's authorized representative shall query the American Medical Association (AMA) or the[PD12] American Osteopathic Association Physician Profiles and the Education Commission for Foreign Medical Graduates (ECFMG) if applicable, regarding the applicant or member and place in the applicant's or member's credentials file. The National Practitioner Data Bank, the OIG/GSA exclusion list, and the relevant professional licensing board shall be queried on all applicants. 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, all such information will be given to the Medical Director for review then to the MEC for recommendation to the Governing Board. The TSC, LLC may use paper or electronic processes for applications, credentialing, and privileging.

4.4.4 MEC ACTION

At its next regular meeting after receipt of the application, or as soon thereafter as is practical, the MEC shall consider the application. The MEC may request additional information, and/or elect to interview the applicant. The MEC shall

render and forward to the Governing Board a written report and decision as to Medical Staff appointment. The MEC may also defer action on the application. The reasons for the decision shall be stated.

Recommendations concerning membership and clinical privileges shall be based on whether the applicant meets the qualifications and can carry out all of the responsibilities specified in the bylaws and TSC, LLC's ability to provide adequate support services and facilities for practitioners.

4.4.5 EFFECT OF MEC ACTION[PD13]

When a final proposed action gives rise to the obligation to file an 805 report in accordance with the California Business and Professions Code § 805(b), the Governing Board shall be promptly informed in writing and the applicant shall be promptly informed by written notice in accordance with California Business and Professions Code § 809.1 and shall then be entitled to the procedural rights as provided in Article VII. AHPs do not have hearing rights as provided in these bylaws.

4.4.6 ACTION ON THE APPLICATION[PD14]

The Governing Board may accept the recommendation of the MEC or may refer the matter back to the MEC for further consideration, setting the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

(a) If the MEC issues a favorable recommendation, the Governing Board shall affirm the recommendation of the MEC, refer the matter back to the MEC, or decide not to concur.

(1) If the Governing Board concurs in that recommendation, the decision of the Governing Board shall be deemed final action.

(2) If the final proposed action gives rise to the obligation to file an 805 report in accordance with the California Business and Professions Code § 805(b), the applicant shall be promptly informed by written notice in accordance with California Business and Professions Code § 809.1 and shall then be entitled to the procedural rights as provided in Article VII. If the applicant waives his or her procedural rights, the decision of the Governing Board shall be deemed final action.[PD15]

(b) In the event the final proposed action of the MEC, or any significant part of it, gives rise to the obligation to file an 805 report in accordance with the California Business and Professions

Code § 805(b), the procedural rights set forth in Article VII shall apply.[PD16]

(1) If the applicant waives his or her procedural rights, the recommendations of the MEC shall be forwarded to the Governing Board for final action, which shall affirm the recommendation of the MEC if the decision is supported by substantial evidence.

(2) If the applicant requests a hearing, the Governing Board shall take final action only after the applicant has exhausted his or her procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, subject only to the rights of appeal as set forth in these bylaws, the Governing Board shall make a final decision and shall affirm the decision of the Judicial Review Committee if it is supported by substantial evidence following a fair procedure. The Governing Board's decision shall be in writing and shall specify the reasons for the action taken.

4.4.7 NOTICE OF FINAL DECISION[PD17]

(a) Notice of the final decision shall be given to the applicant in writing.

(b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the clinical privileges granted; and (2) any special conditions attached to the appointment.

4.4.8 TIMELY PROCESSING OF APPLICATIONS

Applications for Medical Staff appointments shall be considered in a timely manner as stated in the credentialing policies and procedures. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications:

(a) Evaluation, review, and verification of application and all supporting documents sixty (60) days after receipt of all necessary documentation;

(b) Review and recommendation by MEC thirty (30) days after receipt of all necessary documentation.

4.5 REAPPOINTMENT[PD18]

Medical staff privileges must be periodically reappraised, not less than every two (2) years. The scope of procedures performed at TSC, LLC must be periodically reviewed and amended as appropriate.

4.5.1 REAPPLICATION

At least three (5) months prior to the expiration date of the current staff appointment, a reapplication form shall be mailed or delivered to the member. At least thirty (90) days prior to the expiration date, each Medical Staff member shall submit to the CVO designee the completed application form for renewal of appointment to the staff, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.4.1, as well as other relevant matters. On receipt of the application, the information shall be processed as set forth commencing at Section 4.4.3.

4.5.2 FAILURE TO FILE REAPPOINTMENT APPLICATION

If the member fails without good cause to file a completed application within forty-five (45) days past the date it was due, the member shall be deemed to have resigned membership from the TSC, LLC Medical Staff, as of the date of expiration of his/her appointment, and the procedures set forth in Article VII shall not apply.

ARTICLE V. CLINICAL PRIVILEGES[PD19]

5.1 EXERCISE OF PRIVILEGES

A member providing clinical services at this surgery center shall be entitled to exercise only those clinical privileges specifically granted. These privileges and services must be organization specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon. Medical Staff privileges may be granted, continued, modified or terminated by the Governing Board of TSC, LLC after considering the recommendation of the MEC, and only for reasons directly related to quality of patient care and other provisions of the Medical Staff bylaws, and only following the procedures outlined in these bylaws.

5.2 DELINEATION OF PRIVILEGES IN GENERAL[PD20]

5.2.1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant and are limited to those privileges currently held at an area acute care facility. A

request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2.2 BASES FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from outside sources and appropriateness of procedure for an ambulatory surgery center setting.

5.3 PROCTORING

5.3.1 GENERAL PROVISIONS

Except as otherwise determined by the MEC, all new members and all members granted new clinical privileges shall be subject to a period of review. Performance on three (3) procedures has been established by the MEC, to determine suitability to continue to perform services within the Surgery Center. Monitoring reports available at accredited local hospitals may be accepted in lieu of fifty percent (50%) of the monitoring reports required to be completed at the Surgery Center. Monitoring reports must be as described in section 3.4.3 and completed by a physician appointed by the MEC. The Medical Director will review, evaluate and make recommendations to the MEC through the use of physician monitoring records and other quality data.

5.3.2 FAILURE TO OBTAIN CERTIFICATION

If a new member or member exercising new clinical privileges fails to obtain such certification within the time allowed by the MEC those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, on request, pursuant to Article VII, if such failure is due to a Medical Disciplinary Cause or Reason.

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4.1 GENERAL EXCEPTIONS TO PREROGATIVES

Limited license members:

(a) shall exercise clinical privileges only within the scope of their licensure and as set forth below.

5.4.2 ADMISSIONS

When dentists, oral surgeons, and podiatrists provide care to patients within the ambulatory care center, the patient's primary care provider or cardiologist (licensed MD/DO) has completed the medical portion of the H&P exam and has provided medical clearance for the patient to be admitted to the surgery center. Alternatively, a physician member of the Medical Staff ~~must~~ may conduct or directly supervise the care provided by the limited license practitioner, except the portion related to dentistry or podiatry, and assume responsibility for the care of the patient's medical ~~problems which~~problems, which are outside of the limited license practitioner's lawful scope of practice.

5.4.3 SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of a physician member of the Medical Staff with surgical privileges.

5.4.4 MEDICAL APPRAISAL

All patients admitted for care at the Surgery Center by a dentist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists or podiatrists shall consult with a physician member to determine the patient's medical status and a need for medical evaluation.

5.5 TEMPORARY PRIVILEGES

5.5.1 CIRCUMSTANCES

(a) Temporary privileges may be granted where good cause exists to a physician for the care of specific patients but for not more than four (4) patients per calendar year provided that the procedure described in Section 5.5.2 has been followed.

(b) Following the procedures in Section 5.5.2, temporary privileges may be granted to a person serving as a locum tenens for a current member of the TSC, LLC Medical Staff. Such person may attend the patients of the member for whom the person is serving as locum tenens and only for a period not to exceed ninety (90) days per calendar year, unless the MEC recommends a longer period for good cause.

5.5.2 APPLICATION AND REVIEW

(a) On receipt of a completed application and supporting documentation from a physician, dentist, or podiatrist authorized to practice in California, the MEC may grant temporary privileges to

a practitioner who appears to have qualifications, ability and judgment, consistent with Section 2.2.1, but only after:

(1) The MEC has contacted at least one person who:

a. Has recently worked with the applicant;

b. Has directly observed the applicant's professional performance over a reasonable time; and

c. Provides reliable information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care.

(2) The appropriate licensing board, the National Practitioner Data Bank, and the OIG/GSA exclusion list have been queried, the answer shall have been received and it has been deemed acceptable by the Medical Director.

(3) The applicant's file is forwarded to the MEC.

(4) Reviewing the applicant's file and attached materials, the MEC recommends granting temporary privileges.

5.5.3 GENERAL CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the Medical Director within TSC, LLC.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the MEC or unless affirmatively renewed following the procedure as set forth in Section 5.5.2.

(c) Requirements for proctoring and monitoring including, but not limited to, those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances.

(d) Temporary privileges may at any time be terminated by the Medical Director or MEC. In such cases, the Medical Director or MEC shall assign a member of the TSC, LLC Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member. Terminations for Medical Disciplinary Cause or Reason give rise to the hearing rights specified in Article VII.

(e) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the TSC, LLC Medical Staff.

5.6 LEAVE OF ABSENCE

5.6.1 A Medical Staff member may request a voluntary leave of absence from the Medical Staff by submitting a written notice to the MEC. The request must state the approximate period of leave desired, which may not exceed one (1) year, and include the reasons for the request. Upon written request of the Medical Staff member to the MEC, and at the discretion of the MEC, an approved leave may be extended to two (2) years. During the period of leave, the Practitioner shall not exercise clinical privileges at the Surgery Center, and membership prerogatives and responsibilities shall be in abeyance. The request may be granted or denied, in whole or in part, at the discretion of the MEC with Governing Board Approval. In making its decision, the MEC shall consider the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Surgery Center by the absence of the member requesting the leave. All Medical Staff members requesting a leave of absence are expected to complete all medical records and Medical Staff and Surgery Center matters prior to commencing the leave of absence, unless, in the judgment of the MEC, the member has a physical or psychological condition that prevents him/her from completing records and/or concluding other Medical Staff or Surgery Center matters.

5.6.2 A leave of absence may be granted for any reason approved by the MEC and the Governing Board including, but not limited to, the following reasons:

(a) Medical Leave of Absence

A Medical Staff member may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or impairment.

(b) Military Leave of Absence

A Medical Staff member may request and be granted a leave of absence to fulfill military service obligations.

(c) Educational Leave of Absence

A Medical Staff member may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with these Bylaws.

(d) Personal/Family Leave of Absence

A Medical Staff member may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor) or family reasons (e.g., maternity leave).

5.6.3 Termination of Leave

At least thirty (30) days prior to the requested termination of the leave of absence, the Medical Staff member may request reinstatement of Medical Staff membership and clinical privileges by submitting a written notice to the MEC. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the criteria listed in Section 2.2 of these Bylaws or, if changes have occurred, a detailed description of the nature of the changes. In addition, the MEC may request any information or evidence it deems relevant to the decision to reinstate a Practitioner to the Medical Staff including, but not limited to, medical records of Practitioner. If so requested, the Medical Staff member shall submit a summary of relevant activities during the leave which may include, but is not limited to, the scope and nature of professional practice during the leave period and any professional training completed. The MEC may approve or deny the requested reinstatement in whole or in part and may limit or modify the requested reinstatement, including, but not limited to, imposing requirements for monitoring and/or proctoring. If the leave of absence has extended past the Practitioner's reappointment time, he/she will be required to submit an application for reappointment in accordance with these Bylaws and the reinstatement shall be processed as a reappointment.

An adverse decision regarding reinstatement of Medical Staff membership, which is not for a MDCR[PD21], shall not constitute grounds for a hearing under Article VII of these Bylaws.

5.6.4 Failure to Request Reinstatement

The Medical Director will notify the physician in writing no less than 60 days and again no less than 30 days prior to the expiration of a leave of absence. Failure, without good cause, to request reinstatement prior to the end of an approved leave of absence shall be deemed an automatic termination from the Medical Staff.

ARTICLE VI. CORRECTIVE ACTION

6.1 ROUTINE MONITORING AND EDUCATION

The TSC, LLC Medical Staff committees are responsible for carrying out peer review and quality or performance improvement review functions. Following completion of the peer review process, the committees may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out those functions without initiating formal corrective action. Comments, suggestions, and warnings

may be issued orally or in writing. Any such actions, monitoring, or counseling shall be documented in the member's peer review file. MEC approval is not required for such actions, although the actions may be reported to the MEC. The routine monitoring and education actions described in this section shall not constitute a restriction of clinical privileges or grounds for any formal hearing or appeal rights under Article VII.

6.2 CORRECTIVE ACTION

6.2.1 CRITERIA FOR INITIATION

Any person may provide information to the MEC about the conduct, performance, or competence of Medical Staff members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Surgery Center; (2) unethical; (3) contrary to the Medical Staff bylaws and rules or regulations; (4) below applicable professional standards; (5) disruptive of Surgery Center operations; or (6) illegal, a member may request for an investigation or action against such member may be made.

[6.2.2 CRIMINAL ARREST

In the event that an individual is arrested for alleged criminal acts, an immediate investigation into the circumstances of the arrest shall be made. The MEC shall review the circumstances leading to the arrest and may determine if further action is warranted prior to the outcome of the legal action. If the MEC recommends use of a corrective action that fits the definition of an adverse action, this shall entitle the individual subject to such action to notification and the right to a hearing and as set forth in Article VII.]

6.2.3 INITIATION

A request for an investigation must be in writing, submitted to the MEC and supported by reference to specific activities or conduct alleged. If the MEC initiates the request, it shall make an appropriate recordation of the reasons.

6.2.4 INVESTIGATION

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. The MEC may conduct the investigation itself, or may assign the task to an appropriate Medical Staff member or committee. If the investigation is delegated to a member or committee, such person(s) shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as possible. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and on such terms as the investigating body

deems appropriate. The investigating body may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a ‘‘hearing” as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply.

Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.2.5 MEC ACTION

As soon as possible after the conclusion of the investigation, the MEC shall take action which may include, without limitation:

(a) Determining no corrective action be taken and, if the MEC determine there was not 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;

(c) Issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued, the affected member may make a written response which shall be placed in the member’s file;

(d) Recommending the imposition of terms of probation or special limitation on continued TSC, LLC Medical Staff membership including, without limitation, requirement for mandatory consultation, or monitoring; and

(e) Recommending termination of membership.

6.2.6 SUBSEQUENT ACTION

(a) If corrective action as set forth in Section 6.2 is recommended by the MEC, that recommendation shall be transmitted for information to the Governing Board.

(b) The recommendation of the MEC shall be adopted by the Governing Board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII, if applicable, or the Governing Board disagrees with the MEC.

6.2.7 ALTERNATIVE TO CORRECTIVE ACTION

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a hearing as set forth in Article VII hereof, and shall not require reporting to the State Licensure Board or the National Practitioner Data Bank, except as otherwise provide in these Bylaws or required by applicable law. Alternatives to corrective action may include:

(a) Informal discussions or formal meetings regarding the concerns raised about conduct or performance;

(b) Written letters of guidance, reprimand, or warning regarding the concerns about conduct or performance;

(c) Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

(d) Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance and which do not in any way restrict the individual's ability to exercise clinical privileges at the Surgery Center; and/or

(f) Requirements to seek assistance for any impairment.

6.3 SUMMARY RESTRICTION OR SUSPENSION

6.3.1 CRITERIA FOR INITIATION

Whenever failure to immediately suspend or restrict a practitioner may result in imminent danger to the health of any individual, the MEC or any officer thereof, may summarily suspend the membership of such member. Unless otherwise stated, such summary suspension shall become effective immediately on imposition and the person or committee responsible shall promptly give written notice to the member and the Governing Board. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

6.3.2 MEC ACTION

As soon as practical, but no later than seven (7) calendar days after such summary restriction or suspension has been imposed, a meeting of the MEC as a whole shall be convened to review and consider the action. On request, the member may attend and make a statement concerning the issues under investigation, on such

terms and conditions as the MEC may impose. In no event, however, shall any meeting of the MEC, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The MEC may modify, continue, or terminate the summary suspension, but in any event it shall furnish the member with notice of its decision.

6.3.3 PROCEDURAL RIGHTS

If the MEC does not terminate the summary suspension, the member shall be entitled to the procedural rights afforded by Article VII.

6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, membership may be suspended or limited as described, and a hearing, if requested, shall be an informal hearing before the MEC limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

6.4.1 LICENSURE

(a) Revocation, Expiration, and Suspension: Whenever a member's license or other legal credential authorizing practice in this state expires, is revoked or suspended, TSC, LLC Medical Staff membership shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges exercised at the Surgery Center which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status 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.

6.4.2 CONTROLLED SUBSTANCES

(a) Whenever a member's DEA certificate is revoked, limited, suspended, or expires, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a member's DEA certificate 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.

6.4.3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails to satisfy the requirements of Section 10.6.2 shall automatically be suspended from exercising all or such portion of his/her clinical privileges in accordance with the provisions of said Section 10.6.2.

6.4.4 CONVICTION OF FELONY

A Medical Staff member who is convicted of a felony, or who has pled "guilty" or pled "no contest" or its equivalent, in any jurisdiction, to a felony shall immediately and automatically be suspended from practicing at TSC, LLC. Such suspension is effective on conviction and does not await the results of an appeal or the conviction otherwise becoming final. Such suspension shall remain in effect until the matter is resolved by subsequent action by the MEC to dissolve the suspension or to continue it and initiate further corrective action.

6.4.5 MATTERS INVOLVING LICENSE, DRUG ENFORCEMENT ADMINISTRATION CERTIFICATE, FAILURE TO SATISFY SPECIAL APPEARANCE AND FELONY CONVICTION

As soon as practicable after action is taken as described in Section 6.3.1, paragraphs (b) or (c), or in Sections 6.4.2, 6.4.3, 6.4.4and 6.4.5, the MEC shall convene to review and consider the facts on which such action was predicated. The MEC may then recommend such further corrective action as may be appropriate based on information disclosed or otherwise made available and/or may direct that an investigation be undertaken pursuant to Section 6.1.3. With regard to a felony conviction, the MEC shall make a finding of whether the felony is related to the Medical Staff member's basic qualifications, functions, duties or ethical conduct prior to deciding whether to dissolve a suspension or to continue it and initiate further corrective action. Hearing rights are subject to the provisions of Article VII.

6.4.6 CLINICAL RECORDS

Members of the Medical Staff are required to complete clinical records within such reasonable time as may be prescribed by the Medical Director or MEC and in any event, no later than thirty (30) days from the date treatment was provided. A limited suspension in the form of withdrawal of the right to treat future patients at the Surgery Center until clinical records are completed, shall be imposed by the Medical Director or MEC, after notice of delinquency for failure to complete clinical records within such period. Bona fide vacation or illness may constitute

an excuse subject to approval by the Medical Director or MEC. The suspension shall continue until lifted by the Medical Director or MEC.

6.4.7 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated and the member shall not have the right to a hearing pursuant to Article VII.

6.4.8 Misrepresentation

Whenever it is discovered that an individual materially misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, the individual's membership and clinical privileges shall be automatically terminated. The individual may not re-apply for membership or privileges until twenty-four (24) months have passed.

6.4.9 Impaired Practitioner

Should a Practitioner or Allied Health Professional appear or become impaired while providing patient care, the Medical Director or Administrator shall be notified immediately. Impaired shall mean illness, suspected drug abuse or suspected alcohol intoxication if such could reasonably interfere with the Practitioner's or Allied Health Professional's competent performance of procedures at the Surgery Center. Should the Medical Director or Administrator determine that a Practitioner or Allied Health Professional is impaired as defined above, the Practitioner or Allied Health Professional shall be denied or removed from patient contract until it has been determined that the individual is no longer impaired[PD22].

6.4.10 AUTOMATIC RESIGNATION

(1) Relocation

Unless otherwise approved by the Governing Board upon recommendation of the MEC, any Practitioner or other individual with clinical privileges who takes up permanent residence more than a reasonable distance, as determined by the Governing Board, from the Surgery Center shall be deemed to have resigned from the Medical Staff and relinquished all clinical privileges.

(2) Failure to Apply for Reappointment or Renewal of Privileges

A term of medical staff membership or the granting of clinical privileges shall be for a period of no more than two (2) years. In the event that reappointment or a renewal of clinical privileges has not occurred for whatever reason prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual shall be terminated. The individual shall be notified of the termination and the need to submit a new application if continued membership or clinical privileges are desired. The failure to seek reappointment or renewal of clinical privileges prior to the expiration of the current term of appointment shall not give rise to the hearing and appellate rights set forth in Article VII.

ARTICLE VII. HEARINGS AND APPELLATE[PD23] REVIEWS[PD24]

These procedures apply to all applicant/member physicians, dentists, and podiatrists applying to practice or practicing within the Surgery Center.

7.1 STATEMENT OF PURPOSE

The following procedures are set forth in order to help ensure that a professional review action is taken in the reasonable belief that the action is in the furtherance of quality health care; that a reasonable effort is made to obtain the facts of the matter; that adequate notice and hearing procedures are afforded to the Practitioner involved and that any action eventually taken is warranted by the facts ascertained. All committees, panels, and boards charged with responsibility under Article VII and Article IX of these Bylaws shall evaluate and improve the quality of care rendered at the Surgery Center. The procedures set forth in this Article VII shall apply exclusively to Practitioners.

7.2 INTERVIEWS

Any interviews conducted pursuant to these bylaws shall neither constitute, nor be deemed, a "hearing," as described in this Article VII, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. When the MEC or the Governing Board is considering an independent adverse recommendation, as defined in Section 7.3, or when otherwise deemed appropriate by the MEC or Governing Board, the MEC or Governing Board may offer the Medical Staff member an interview. In the event an interview occurs, the Medical Staff member may be informed of the general nature of the circumstances leading to such recommendation and may present information relevant thereto. In an interview, neither the Medical Staff member nor the MEC is entitled to representation by an attorney. A record of the matters discussed and findings resulting from such interview may be made.

7.3 GROUNDS FOR HEARING

7.3.1 Recommendations or Actions Triggering Right to Hearing

The following recommendations or actions shall, if deemed adverse pursuant to Section 7.3.5 of these Bylaws, entitle the affected Practitioner to a hearing:

1. Denial of initial staff appointment for a MDCR;
2. Denial of reappointment for a MDCR;
3. Suspension of staff membership for a MDCR lasting longer than 14 days;
4. Termination or revocation of staff membership for a MDCR;
5. Denial of requested advancement in staff category for a MDCR;
6. Reduction in staff category for a MDCR;
7. Denial of requested clinical privileges for a MDCR;
8. Restriction of or reduction in clinical privileges for a cumulative total of 30 days or more in any 12-month period, for a MDCR;
9. Suspension of clinical privileges for a MDCR lasting longer than 14 days;
10. Termination or revocation of clinical privileges for a MDCR; or
11. Individual requirement of consultation for a MDCR.

7.3.2 Recommendations or Actions Not Triggering Right to Hearing

There shall be no right to a hearing in situations not listed in Section 7.3.1. These situations include, but are not limited to, a warning letter of reprimand or censure, a mandatory personal appearance, a notification requirement (which may require an individual to give reasonable notice of performance of certain procedures but does not require consultation or approval or presence of a proctor prior to the individual beginning the procedure), any voluntary resignation or relinquishment of privileges, or any action based on the individual's failure to meet minimum objective

standards for membership or any specific clinical privilege that apply to all similarly situated individuals. For example, the possession of a medical license is required for membership, and there are certain required activity levels such as numbers of particular procedures per year.

7.3.3 When Necessary Facilities and Support Are Unavailable

Additionally, there shall be no right to a hearing for a Practitioner whose application for Medical Staff membership or request for an extension of clinical privileges was declined on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the Surgery Center. Similarly, there shall be no right to a hearing if the Surgery Center makes a policy decision (*e.g.*, closing a service, or a physical plant change) that adversely affects the staff membership or clinical privileges of any Member or any other individual.

7.3.4 Exclusive Contracting

The Surgery Center may refuse to accept an application for appointment or reappointment on the basis of an exclusive professional contract that the Surgery Center has entered into for services. Upon receipt of such an application, the Medical Director shall notify the applicant in writing that the application cannot be processed because of the existence of such an exclusive contract. No applicant whose application is denied on such a basis shall be afforded any of the procedural rights set forth in Article VII of these Bylaws. Further, no Practitioner shall be afforded any of the procedural rights set forth in Article VII of these Bylaws due to the loss of the ability to perform services at the Surgery Center as a result of the Surgery Center entering into an exclusive professional contract with other Practitioners.

7.3.5 When Deemed Adverse

A recommendation or action listed in Section 7.3.1 of these Bylaws shall be deemed adverse only when it has been:

1. Recommended by the MEC; or

2. Taken by the Governing Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

3. Taken by the Governing Board on its own initiative without benefit of a prior recommendation by the MEC.

7.4 EXHAUSTION OF REMEDIES

If any of the above adverse action is taken or recommended, the member must exhaust the remedies afforded by these procedures before resorting to legal action.

7.5 NOTICE OF REASONS/ACTION

Whenever any of the actions listed above are taken or proposed for a non-MDCR, the member shall receive a written statement of the reasons therefore. However, the Article VII sections below apply only where action was taken or proposed for a MDCR.

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 7.3.5 of these Bylaws shall promptly be given special notice of such action. Such special notice shall be sent by the Center Representative by hand or by certified or registered mail. Such notice shall:

1. Advise the Practitioner that a professional review action has been proposed to be taken against him;

2. State the reasons for the proposed action;

3. Alert the Practitioner that he has thirty (30) days following the date of receipt of notice in which to request a hearing on the proposed action and that failure to request a hearing within thirty (30) days shall constitute a waiver of his right to a hearing on the matter;

4. Advise the Practitioner that the Surgery Center may be required pursuant to Section 805 of the California Business and Professions Code to report the proposed action, if taken; and [PD25]

5. Provide a summary of his rights at such a hearing under these Bylaws.

7.6 HEARING

7.6.1 Request for a Hearing

A Practitioner shall have thirty (30) days following his or her receipt of a notice pursuant to Section 7.5 to file a written request for a hearing. A Practitioner's receipt of the notice of the proposed action shall be irrebuttably presumed four (4) days after the date of the certified or registered mailing, or, if hand-delivered, on the date of delivery. Any request for a hearing must be received by the Center Representative within the thirty (30) day timeframe. The request for a hearing

shall contain a statement, signed by the Practitioner, that the Practitioner shall maintain confidentially all documents provided to him during the fair hearing process and shall not disclose or use the documents for any purpose outside of the fair hearing process or any lawsuit directly related to the hearing process.

7.6.2 Waiver by Failure to Request a Hearing

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.6.1 waives any right to such a hearing to which he might otherwise have been entitled. Such waiver in connection with:

1. An adverse action by the Governing Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Surgery Center. This decision shall be immediately effective and shall not be subject to further hearing, appellate, or judicial review.

2. An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Governing Board. The Governing Board shall consider the MEC's recommendation at its next regular meeting following waiver. In its deliberations, the Governing Board shall review all the information and material considered by the MEC and may consider all other relevant information received from any source. The Governing Board's action shall constitute the final decision of the Surgery Center. This decision shall be immediately effective and shall not be subject to further hearing, appellate, or judicial review.

The Center Representative shall promptly send the Practitioner special notice informing the Practitioner of each action taken pursuant to this Section 7.6.2 and shall notify the Governing Board of each such action. Such special notice shall be sent by hand or by certified or registered mail.

7.6.3 Number Of Hearings

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one hearing with respect to an adverse recommendation or action.

7.7 HEARING PREREQUISITES

7.7.1 Notice Of Time And Place Of Hearing

Upon receipt of a timely request for hearing, the Center Representative shall deliver such request to the Governing Board and the MEC. At least thirty (30)

days prior to the hearing, the Center Representative shall send the Practitioner special notice of the time, place, and date of the hearing. Such special notice shall be sent by hand or by certified or registered mail. The hearing date shall be not less than thirty (30) days from the date of receipt of the request for hearing. The notice of hearing shall identify the Practitioners who will comprise the Judicial Review Committee. The notice of hearing shall also contain a list by number of the specific or representative patient records (if any) in question and a list of witnesses (if any) expected to testify at the hearing at the request of the Judicial Review Committee. These lists may be amended at a later date, and the amended list of records and witnesses shall be provided to the Practitioner prior to the hearing. Nothing in this section, however, shall preclude the Judicial Review Committee, in its sole discretion, from calling additional witnesses whose testimony is determined to be relevant by the Judicial Review Committee.

7.7.2 Appointment Of Judicial Review Committee

1. A hearing occasioned by an adverse recommendation pursuant to Section 7.3.5 shall be conducted by a Judicial Review Committee appointed by the Medical Director and composed of three (3) members of the Active Medical Staff who (1) are in good standing, (2) are unbiased with respect to the subject matter of the hearing, (3) do not stand to gain any direct financial benefit from the outcome of the hearing, and (4) have not acted as an accuser, investigator, fact finder or initial decision-maker in the same matter. Knowledge of the matter involved shall not preclude a member from serving as a member of the Judicial Review Committee. If feasible, subject to the requirements of Section 7.7.3(2) below, at least one (1) of the Judicial Review Committee members should be a Practitioner practicing in the same specialty as the Practitioner who is the subject of the hearing.

2. No Practitioner in direct economic competition with the Practitioner may serve as a Judicial Review Committee member. A Practitioner shall be disqualified from serving on a Judicial Review Committee if he has participated in initiating, investigating, or making decisions regarding the underlying matter at issue. Members who serve on the Governing Board may be appointed to serve on a Judicial Review Committee only if the Medical Director determines in good faith that the number of Active Medical Staff Members otherwise eligible to participate on the Judicial Review Committee is not sufficient to constitute a Judicial Review Committee the membership of which does not overlap with the Governing Board. In such case, any member of the Governing Board who serves on a Judicial Review Committee shall be excluded from considering and voting on the matter as a member of the Governing Board.

7.7.3 Objection To Judicial Review Committee Composition

Upon receipt of notice provided in Section 7.5, the Practitioner shall have a reasonable opportunity to *voir dire* the Judicial Review Committee members and, within five (5) days after such *voir dire*, to object in writing to the participation of any members of the Judicial Review Committee. Such written objection shall be delivered by hand or by certified or registered mail to the Hearing Officer. Any objection to the composition of the Judicial Review Committee must be based on the Practitioner's reasonable and good faith belief that one (1) or more individuals selected to serve on the Judicial Review Committee are not impartial with respect to the subject matter of the hearing or the Practitioner at issue. The Hearing Officer shall, in his or her sole discretion, determine whether new Judicial Review Committee members should be appointed to replace the members to whom the Practitioner objected. If no objection is made in writing prior to the later of five (5) days after the *voir dire* or ten (10) days after the Practitioner's receipt of the notice provided pursuant to Section 7.5 if the Practitioner has not requested a *voir dire* by such time, the Practitioner shall be deemed to have waived any objection to the Judicial Review Committee's composition.

7.10 HEARING PROCEDURE

7.10.1 Personal Presence

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause, as determined by the Judicial Review Committee in its sole discretion, to appear at such hearing shall be deemed to have waived his rights in the same manner and with the same consequence as provided in Section 7.5.2.

7.10.2 Presiding Officer

The Hearing Officer shall act as the presiding officer. The Hearing Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Hearing Officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

7.10.3 The Hearing Officer

The Governing Board on recommendation of the MEC may appoint a Hearing Officer to preside at the hearing. The Hearing Officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by TSC, LLC for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting Officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in

the hearing have a reasonable opportunity to be hard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary actions as seems warranted by the circumstances. If requested by the Judicial Review Committee, the Hearing Officer may participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but shall not be entitled to vote.

7.10.4 Notice By Practitioner

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or other person of the Practitioner's choice. At least ten (10) days prior to the hearing, the Practitioner shall provide the name of his attorney or other representative and a list of witnesses he will call. The Practitioner shall deliver such notice by hand or by certified or registered mail to the Center Representative, who shall promptly forward a copy of such notice to the Judicial Review Committee. The Practitioner's list of witnesses may be amended at any time for good cause shown. The Judicial Review Committee shall, in its sole discretion, determine whether good cause has been shown. The MEC or the Governing Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to represent the facts in support of its adverse recommendation or action, and to examine witnesses.

7.10.5 Rights Of Parties

During a hearing, each of the parties shall, as soon as practicable,:

1. Have access to all of the information made available to the Judicial Review Committee;

2. Be afforded a reasonable time to present his case by:

    a. Calling and examining witnesses;
    b. Introducing exhibits;
    c. Cross-examining any witness on any matter relevant to the issues; and
    d. Presenting and rebutting any evidence determined by the Hearing Officer to be relevant.

3. Have the right to present a written statement at the close of the hearing; and

4. Obtain a copy of the record upon payment of any reasonable charges associated with the preparation thereof and upon signing a stipulation agreeing to maintain the record confidentially.

If the Practitioner who requested the hearing does not testify in his own behalf, he may be called and examined as if under cross-examination.

7.10.6 Access To Information and Documents

The Practitioner shall have the right to inspect and copy at his or her own expense any documentary information relevant to the action or recommendation at issue which the MEC has in its possession or under its control, as soon as practicable after the receipt of the Practitioner's request for a hearing. The MEC shall have the right to inspect and copy at the its own expense any documentary information relevant to the action or recommendation at issue which the Practitioner has in his or her possession or control as soon as practicable after receipt of the MEC's request. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners, other than the Practitioner under review. The Hearing Officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires.

When ruling upon requests for access to information and determining the relevancy thereof, the Hearing Officer shall consider the following:

1. Whether the information sought may be introduced to support or defend the recommendation or action against the Practitioner;

2. The exculpatory or inculpatory nature of the information sought, if any;

3. The burden imposed on the party in possession of the information sought, if access is granted;

4. Any previous requests for access to information submitted or resisted by the parties to the same proceeding; and

5. Such other factors as the Hearing Officer deems appropriate.

The member shall be entitled to representation by legal counsel in any phase of the hearing, should he/she so choose, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitle to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the state of California, who is not also an

attorney at law, and the MEC shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The MEC shall not be represented by an attorney at law if the member is not so represented.

7.10.7 Procedure And Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs, including hearsay, shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party will file documentary evidence within ten (10) days in advance of the hearing. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. The Hearing Officer shall not allow a witness to attend the hearing and may require that a witness take an oath before testifying. A record of the hearing shall be made by use of a court reporter or an electronic recording unit. The Judicial Review Committee shall be entitled to legal counsel or other representation in all hearings and proceedings.

7.10.8 Official Notice

In reaching a decision, the Judicial Review Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Judicial Review Committee. The Judicial Review Committee shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

7.10.9 Burden Of Proof

The burden of presenting evidence and proof during the hearing shall be as follows:

1. The MEC or the Governing Board, depending on whose recommendation or action prompted the hearing, shall have the initial duty to present evidence which supports the recommendation or action.

2. Initial applicants shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for Medical Staff membership and clinical privileges. Initial applicants shall not be permitted to introduce information not produced during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

3. Except as provided above for initial applicants, the MEC or the Governing Board, depending on whose recommendation or action prompted the hearing, shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

7.10.10 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the time permitted in these bylaws may be permitted by the Hearing Officer on a showing of good cause, or on agreement of the parties

7.10.11 Presence Of Judicial Review Committee Members

Each member of the Judicial Review Committee must be present throughout the hearing and deliberations.

7.10.12 Recesses And Adjournment

The Judicial Review Committee or the Hearing Officer, upon consultation with the Judicial Review Committee, may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Judicial Review Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The Judicial Review Committee may seek legal counsel during its deliberations and the preparation of its report. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

7.10.13 Judicial Review Committee Report

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the parties and to the Governing Board. If the member's membership is currently suspended however, the time for the decision and report shall be fifteen (15) days. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these bylaws. On an appeal, the Appeal Board shall give great weight to the decision of the Judicial Hearing Committee and in no event shall act in an arbitrary or capricious manner in making its decision. The Appeal Board shall decide whether there was substantial compliance with these bylaws and applicable law, whether the Judicial Hearing Committee decision was supported by the evidence based on the hearing record, and if the action was taken arbitrarily, unreasonably, or capriciously. Both the member and the MEC shall be provided a written explanation of the procedure for appealing the decision.

7.11 APPEAL

7.11.1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the Judicial Review Committee either the member or the MEC may request an appellate review. A written request for such review shall be delivered to the Governing Board. If a request for appellate review is not made within such period, that action or recommendation shall be affirmed by the Governing Board as the final action, if it is supported by substantial evidence following a fair procedure.

7.11.2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

(a) Substantial non-compliance with the procedures required hereunder or applicable law which has created demonstrable prejudice;

(b) The decision was not supported by the evidence based on the hearing record or such additional information as may be permitted pursuant to Section 7.11.5, below.

7.11.3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the Appeal Board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a member whose membership has been summarily suspended, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the Appeal Board for good cause.

7.11.4 APPEAL BOARD

The Governing Board of TSC, LLC, or a committee thereof, shall act as the Appeal Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person was not previously involved with the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

7.11.5 APPEAL PROCEDURE

The proceedings by the Appeal Board shall be in the nature of an appellate hearing based on the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination and confrontation provided at the hearing; or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal and to personally appear and make oral argument. The Appeal Board may thereon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives.

7.11.6 DECISION

(a) Except as provided in Section (b), below within thirty (30) days after the conclusion of the appellate review proceedings, the Appeal Board shall affirm, modify, reverse, or remand for further review the Judicial Review Committee's decision.

(b) Should the Appeal Board determine that the Judicial Review Committee's decisions are not supported by the evidence, the Appeal Board may modify or reverse the decision and may instead, or shall, where a fair procedure has not been afforded, remand the matter back for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Judicial Review Committee shall promptly conduct its review and make its recommendations to the Appeal Board. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Appeal Board and the Judicial Review Committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the MEC and the subject of the hearing. The decision shall be final.

7.12 REAPPLICATION

Following an adverse final decision by the Governing Board, the Practitioner may not reapply for appointment to the Medical Staff or for clinical privileges, whichever is applicable, for at least twenty-four (24) months after the Governing Board's final decision or in a manner that is inconsistent with the Governing Board's final decision.

7.14 EXTERNAL REPORTING REQUIREMENTS

The Surgery Center shall submit a report regarding a final adverse action to the appropriate state professional licensure board (i.e., the state agency that issued the individual's license to practice) and all other agencies as required by all applicable Federal and/or State law(s).

ARTICLE VIII. OFFICERS[PD26][PD27]

8.1 OFFICERS OF THE MEDICAL STAFF

8.1.1 IDENTIFICATION

The officers of the Medical Staff shall be a president, a secretary and a chief financial officer.

8.1.2 QUALIFICATIONS

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

8.1.3 ELECTION

Officers shall be elected by the shareholders of Truckee Surgery Center, Inc.

8.1.4 TERM OF ELECTED OFFICE

Each officer shall serve a two (2)-year term, commencing on the first day of the Medical Staff year following his or her election. Each officer shall serve in each office until the end of that officer's term, or until a successor is appointed, unless that officer shall sooner resign or be removed from office.

8.1.5 VACANCIES IN ELECTED OFFICE

Vacancies in office occur on the death or disability, resignation, or removal of the officer, or such officer's loss of membership on the Active Medical Staff. Vacancies shall be filled by appointment by the MEC until the next regular election.

8.2 MEDICAL DIRECTOR

8.2.1 SELECTION The Medical Director shall serve at the pleasure of the Governing Board as the chief officer of the Medical Staff. The Medical Director shall enter into a contract with TSC, LLC and shall be required to attain Medical Staff membership and clinical privileges as a condition of that contract. As a contractor, the Medical Director is subject to the regular personnel policies of TSC, LLC and the terms of the Medical Director contract.

8.2.2 DUTIES

The duties of the Medical Director shall include, but not be limited to:

(a) Enforcing the Medical Staff bylaws and rules and regulations, 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 chairman of the MEC;

(d) Serving as an ex officio member of all other staff committees without vote, unless his or her membership in a particular committee is required by these bylaws;

(e) Appointing, in consultation with the MEC, committee members for all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by these bylaws and,

except where otherwise indicated, designating the chairman of these committees; and

(f) Performing such other functions as may be assigned to the Medical Director by these bylaws, the Medical Staff, or by the MEC and Governing Board;

(g) Interacting with the Governing Board in all matters of mutual concern within TSC, LLC.

8.2.3 TERMINATION

(a) The Medical Director may be terminated only by the Governing Board of TSC, LLC.

(b) The Medical Director's contract prevails over these Bylaws except that the Medical Director's contract may not be terminated for a Medical Disciplinary Cause or Reason without the hearing rights provided in Article VII.

(c) If action is taken against the Medical Director that gives rise to a right to a hearing under Article VII, the provisions Article VII shall govern the action.

ARTICLE IX. COMMITTEES

9.1 DESIGNATION

Medical staff committees shall include but shall not be limited to the Medical Staff meeting as a committee of the whole, meetings of committees established under this Article, and meetings of ad hoc or special committees created by the MEC. Unless otherwise specified, the chairman and members of all committees shall be appointed by and removed by the Medical Director, subject to consultation with and approval by the MEC.

9.2 GENERAL PROVISIONS

9.2.1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of one year, 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.

9.2.2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, or suffers a loss or significant limitation of practice privileges, fails

to attend a minimum of fifty percent (50%) of scheduled meetings, or if any other good cause exists, that member may be removed by the MEC.

9.2.3 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 an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the MEC.

9.3 MEC[PD28]

9.3.1 COMPOSITION

The MEC shall consist of the officers of the Medical Staff, the Medical Director and two (2) Active Staff Members elected by the Active Medical Staff Members.

9.3.2 DUTIES

The duties of the MEC shall include, but not be limited to:

(a) Coordinating and implementing the professional and organization activities and policies of the Medical Staff;

(b) Receiving and acting on reports and recommendations from Medical Staff committees;

(c) Recommending action to the Governing Board on matters of a medical-administrative nature;

(d) Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities, the procedures for termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of the Surgery Center.

(e) Maintaining members' credentials files;

(f) Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and Medical Staff members and making recommendations to the Governing Board regarding staff appointments, reappointments, and corrective action:

(g) Initiating corrective action when warranted:

(h) Designating such committees and making appointments to those committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff;

(i) Assisting in the obtaining and maintenance of accreditation;

(j) Designating TSC, LLC's authorized representative for National Practitioner Data Bank purposes, if applicable;

(k) Reviewing Medical Staff bylaws and rules and regulations as needed and making recommendations for modifications to these documents as necessary;

(l) Recommending to the Governing Board appropriate administrative policies and procedures regarding employment of personnel, fiscal concerns and the purchasing of equipment.

(m) Recommending appointments of the Medical Staff officers to the Governing Board.

(n) The MEC will perform the following Medical Staff functions: 1) clinical records; 2) utilization review; 3) pharmacy and therapeutics; 4) quality management; 5) allied health professionals; 6) patients' rights; 7) safety; and 8) infection control.

(o) Reporting to the Medical Staff, at least annually, the findings and results of all Medical Staff quality management activities.

9.3.3 MEETINGS

The MEC shall meet as often as necessary, but at least quarterly and shall maintain a record of its proceedings and actions.

9.4 CLINICAL RECORDS

9.4.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Reviewing and evaluating clinical records, or a representative sample, to determine whether they: (1) properly describe the condition and diagnosis, the progress of the patient, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and (2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services at the Surgery Center;

(b) Reviewing and making recommendations for TSC, LLC policies, rules and regulations relating to clinical records, including completion, forms and formats, filing, indexing, storage, destruction, availability and methods of procedure enforcement;

(c) Providing liaison between practitioners and personnel in the employ of TSC, LLC on matters relating to clinical records practices; and

(d) Formulating procedures which assure that records are treated confidentially as required by applicable law.

9.5 UTILIZATION REVIEW

9.5.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Conducting utilization review studies designed to evaluate the necessity and appropriateness of admissions to the Surgery Center, discharge practices, use of medical services and related factors which may contribute to the effective utilization of services;

(b) Establishing a utilization review plan.

(c) Obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by TSC, LLC's case management system; and

(d) Reviewing the resources of care provided at the Surgery Center with respect to:

1. The absence of duplicative diagnostic procedures;

2. The appropriateness of treatment frequency;

3. The use of the least expensive alternative resources when suitable; and

4. The use of ancillary services that are consistent with patient's needs.

9.6 PHARMACY AND THERAPEUTICS

9.6.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, disposal, and all other matters relating to drugs at the Surgery Center;

(b) Periodically developing and reviewing a formulary or drug list for use at the Surgery Center;

(c) Evaluating clinical data concerning new drugs or preparations requested for use at the Surgery Center;

(d) Reviewing and reporting adverse reactions to drugs;

(e) Monitoring medication errors and referring such for corrective action, when necessary;

(f) Evaluating the appropriateness of blood transfusions; and

(g) Developing proposed policies and procedures for the handling and administration of blood and blood components; and

(h) Assuring the maintenance of a current pharmacy license.

9.7 QUALITY MANAGEMENT

9.7.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Recommending, for approval by the Governing Board, a written plan(s) for maintaining quality patient care at TSC, LLC;

(b) Submitting regular confidential reports to the Governing Board on the quality of medical care provided and on quality review activities conducted;

(c) Collecting data related to established criteria in an ongoing manner;

(d) Periodically evaluating data to identify unacceptable or unexpected trends or occurrences that influence patient outcomes;

(e) Evaluating the frequency, severity, and source of suspected quality problems or concerns:

(f) Implementing measures to resolve quality problems or concerns that have been identified;

(g) Reevaluating quality problems or concerns to determine objectively whether the corrective measures have achieved and sustained the desired result. If the problem remains, taking alternate corrective actions as needed to resolve the problem;

(h) Incorporating findings of quality management activities into TSC, LLC's educational activities; and

(i) Devising and implementing a procedure for the immediate transfer of patients requiring emergency medical care beyond the capabilities of the Surgery Center to a local Medicare-certified hospital and being responsible for transfer agreements to such hospitals.

9.8 ALLIED HEALTH PROFESSIONALS (AHP)

9.8.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include but not be limited to the following:

(a) Recommending to the Governing Board the categories of AHPs eligible to apply for AHP status and practice prerogatives at the Surgery Center;

(b) Establishing procedures regarding:

(1) The mechanism for evaluating the qualifications and credentials of AHPs;

(2) The minimum standards of training, education, character, and competence of AHPs eligible to apply to perform services;

(3) Identification of services which may be performed by an AHP, or category of AHPs, as well as any applicable terms and conditions thereon;

(4) The professional responsibilities of AHPs who have been determined eligible to perform services.

(c) Conducting appropriate monitoring, supervision, and evaluation of AHPs who perform services, provided that:

(1) AHPs not employed by TSC, LLC will be directly supervised by the operating surgeon they are employed by; and

(2) AHPs employed by TSC, LLC will be evaluated by the nurse manager.

9.9 PATIENTS' RIGHTS

9.9.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Formulating procedures which are available to patients and staff which require that:

(1) Patients are treated with respect, consideration, and dignity;

(2) Patients are provided appropriate privacy during interviews, examinations, treatment, and consultation;

(3) Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When a patient does not wish to receive the information, the information is provided to a surrogate decision-maker;

(4) Patients are given the opportunity to participate in decisions involving their health care; and

(5) Patients are provided with information regarding advance directives.

(b) Providing information to patients and staff concerning:

(1) Patient conduct and responsibilities;

(2) Services available at the Surgery Center;

(3) Provision for after-hour and emergency care;

(4) Fees for services and payment policies; and

(5) Methods for expressing grievances and suggestions to TSC, LLC.

(c) Insuring that marketing or advertising regarding the competence and capabilities of TSC, LLC is not misleading to patients.

9.10 SAFETY

9.10.1

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to the following:

(a) Assuring that the Surgery Center has the necessary personnel, equipment, and procedures to handle medical and other emergencies that may arise in connection with services sought or provided;

(b) Providing periodic instruction to all personnel in the proper use of safety, emergency, and fire-extinguishing equipment;

(c) Providing a comprehensive emergency plan to address internal and external emergencies, including evacuation and drill procedures;

(d) Assuring that personnel trained in cardiopulmonary resuscitation and the use of cardiac emergency equipment are present at the Surgery Center during hours of operation;

(e) Assuring that provisions are made to reasonably accommodate disabled individuals;

(f) Assuring that the Surgery Center is clean and properly maintained;

(g) Assuring that a system exists for the proper identification, management, handling, transport, treatment, and disposal of hazardous materials and wastes; and

(h) Assuring that appropriate emergency and other equipment and supplies are maintained, periodically tested and readily accessible.

9.11 INFECTION CONTROL

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to, the following:

(a) Establishing a program for identifying and preventing infections, and maintaining a sanitary environment;

(b) Devising and implementing procedures to minimize sources and transmission of infection, including adequate surveillance techniques; and

(c) Maintaining an ongoing log of reported incidents of infection.

9.12 AD HOC COMMITTEES

Special or ad hoc committees may be created by the MEC to assist with investigations or to perform other specified tasks. The chairman and members of such committees shall be appointed by, and may be removed by the Medical Director in consultation with the MEC.

ARTICLE X. MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1.1 ANNUAL MEETING

There shall be an annual meeting of the Medical Staff. Except as otherwise specified in these bylaws, the Medical Director may establish the times for the holding of the annual meeting. The MEC shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least five (5) days prior to the meeting.

10.2 COMMITTEE MEETINGS

10.2.1 REGULAR MEETINGS

The Medical Director shall make every reasonable effort to ensure that meeting dates are disseminated to the members with adequate notice.

10.3 QUORUM

10.3.1 STAFF MEETINGS

The presence of fifty percent (50%) of the total members of the Active Medical Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these bylaws or the rules and regulations of the Medical Staff. The presence of thirty-three (33%) of such members shall constitute a quorum for all other actions.

10.3.2 COMMITTEE MEETINGS

A quorum shall consist of thirty-three percent (33%) of the voting members of a committee but in no event less than three (3) voting members.

10.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is

approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds (2/3) of the members entitled to vote.

10.5 MINUTES

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

10.6 ATTENDANCE REQUIREMENTS

10.6.1 Each member is encouraged to attend officially called meetings. There are no meeting attendance requirements.

10.6.2 Whenever apparent or suspected deviation from standard clinical practice or disruptive behavior is alleged, seven (7) days advance special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance at a meeting is mandatory. Such a meeting shall be limited to the members of the committee. Failure of a practitioner to appear at any such meeting with respect to which he/she was given such special notice shall, unless excused by the committee on a showing of good cause, result in a recommendation to the MEC for corrective action, to include, but not be limited to, an automatic suspension of all or a portion of the practitioner's clinical privileges. Such suspension shall remain in effect until the matter is resolved by subsequent action of the committee, the MEC or the Governing Board. At the discretion of the chairman, when a Medical Staff member's practice or conduct is scheduled for discussion at a regular committee meeting, the member may be required to attend.

ARTICLE XI. CONFIDENTIALITY OF INFORMATION

11.1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility for evaluation and improvement of quality of care rendered in this surgery center, including, but not limited to, meetings of the Medical Staff as a committee of the whole, meetings of committees, and meetings of special or ad hoc committees created by the MEC and including information regarding any member of applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

11.1.1 CONFIDENTIALITY

The following applies to records of the Medical Staff and its committees responsible for the evaluation and improvement of patient care:

(a) The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered at the Surgery Center shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed persons and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the Governing Board of TSC, LLC -- in order that the Governing Board may discharge its lawful obligations and responsibilities -- shall be maintained by the Governing Board as confidential.

(d) Information contained in the credentials file of any member may be disclosed to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the MEC.

(e) A Medical Staff member shall be granted access to his/her own credentials file, subject to the following provisions:

(1) Timely notice of such shall be made by the member to the MEC.

(2) The member may review, and receive a copy of, only those documents provided by or addressed personally to the member.

(3) The review by the member shall take place during normal work hours, with a designee of the MEC present.

(4) In the event a Notice of Charges is filed against a member, access to his/her own credentials file shall be governed by Section 7.9.5.

11.1.2 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION / DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE

(a) When a member has reviewed his/her file as provided under Section 11.1.1(e) he/she may address to the MEC a written request for correction or deletion of information in his/her credentials file.

Such request shall include a statement of the basis for the action requested.

(b) The MEC shall review such request within a reasonable time and shall decide whether or not to make the correction or deletion requested.

(c) The member shall be notified promptly, in writing, of the decision of the MEC.

(d) In any case, a member shall have the right to add his/her credentials file, on written request to the MEC, a statement responding to any information contained in the file.

ARTICLE XII. ADOPTION AND AMENDMENTS OF BYLAWS, RULES AND REGULATIONS

12.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such rules and regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current Medical Staff practice. Recommended changes to the rules and regulations shall be submitted to the MEC for review and evaluation prior to presentation for consideration by the Medical Staff as a whole under such review or approval mechanism as the Medical Staff shall establish. Following adoption such rules and regulations shall become effective following approval of the Governing Board which approval shall not be withheld unreasonably, or automatically within thirty (30) days if no action is taken by the Governing Board. Applicants and members of the Medical Staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations.

12.2 BYLAWS [PD29]

On the request of the MEC or on timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws. Such action shall be taken at a regular or special meeting provided (1) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the Medical Staff, and such changes were offered at such prior meeting and (2) notice of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered. Both notices shall include the exact working of the existing bylaw language, if any, and the proposed change(s).

12.2.1 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a bylaw change, the change shall require an affirmative vote of fifty-one percent (51%) of the members voting in person or by written ballot.

12.2.2 APPROVAL

Bylaw changes adopted by the Medical Staff shall become effective immediately following approval by the Governing Board, which approval shall not be withheld unreasonably. If approval is withheld, the reasons for doing so shall be specified by the Governing Board in writing, and shall be forwarded to the MEC.

These revised Bylaws were approved by the MEC on _____, and were sent to all Medical Staff members on _____ and were approved on _____. The Governing Board approved them on _____.

_____ _____

Medical Director Date

_____ _____

Governing Board Date

5.4.2 ADMISSIONS

When dentists, oral surgeons, and podiatrists provide care to patients within the ambulatory care center, the patient's primary care provider or cardiologist (licensed MD/DO) has completed the medical portion of the H&P exam and has provided medical clearance for the patient to be admitted to the surgery center. Alternatively, a physician member of the Medical Staff ~~must~~ may conduct or directly supervise the care provided by the limited license practitioner, except the portion related to dentistry or podiatry, and assume responsibility for the care of the patient's medical ~~problems which~~problems, which are outside of the limited license practitioner's lawful scope of practice.

5.4.3 SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of a physician member of the Medical Staff with surgical privileges.

5.4.4 MEDICAL APPRAISAL

All patients admitted for care at the Surgery Center by a dentist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists or podiatrists shall consult with a physician member to determine the patient's medical status and a need for medical evaluation.

5.5 TEMPORARY PRIVILEGES

5.5.1 CIRCUMSTANCES

(a) Temporary privileges may be granted where good cause exists to a physician for the care of specific patients but for not more than four (4) patients per calendar year provided that the procedure described in Section 5.5.2 has been followed.

(b) Following the procedures in Section 5.5.2, temporary privileges may be granted to a person serving as a locum tenens for a current member of the TSC, LLC Medical Staff. Such person may attend the patients of the member for whom the person is serving as locum tenens and only for a period not to exceed ninety (90) days per calendar year, unless the MEC recommends a longer period for good cause.

5.5.2 APPLICATION AND REVIEW

(a) On receipt of a completed application and supporting documentation from a physician, dentist, or podiatrist authorized to practice in California, the MEC may grant temporary privileges to

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Medical Staff

Truckee Surgery Center
General Rules and Regulations

The Medical Staff shall adopt such Rules and Regulations as may be necessary for the proper conduct of its work. Such Amendments shall become effective when approved by the Executive Committee and Governing Body.

I. Admission and Discharge of Patients

A. Admission: only members of the medical staff, with admitting privileges, may admit a patient to the surgery center.

B. Medical Management: All patients entering Truckee Surgery Center, including those for pediatric and dental care, must have a medical staff physician responsible for the overall medical management of the patient, including the performance, and recording in the medical record, of an admission history and physical examination, and when indicated, the patient's ability to undergo surgery and anesthesia.

C. Exceptions: Truckee Surgery Center shall accept all outpatients for care and treatment except patients whose conduct would present a problem regarding their own or other patient's safety, care and comfort.

D. Responsibility: A member of the medical staff shall be responsible for the medical care and treatment of each patient in Truckee Surgery Center and the prompt completeness and accuracy of the medical record.

E. Patient Safety: The admitting physician shall be held responsible for giving such Information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patient might be a source of danger from any cause whatsoever.

F. AMA Discharges: Patients shall be discharged or transferred only on the written order of the attending physician. Should a patient leave Truckee Surgery Center against the medical advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient’s medical record. The patient should sign the appropriate release. If this release is not obtainable, the circumstances shall be documented in the medical record.

G. Transfer/Discharges: No patient shall be transferred or discharged for purposes of affecting a transfer from Truckee Surgery Center to another health facility, unless arrangements have been made in advance to such health facilities. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician, such a transfer or discharge would be detrimental to the patient.

H. Minors/Discharge: A minor shall be discharged only to the custody of his/her parents or legal guardian, unless such parent or guardian shall direct otherwise in writing. This shall not include emancipated minors.

I. Deaths: In the event of a death In Truckee Surgery Center, the deceased shall be pronounced dead within a reasonable time by the attending physician or his physician designee. The body shall not be released until such entry has been made and signed In the medical record of the deceased by a member of the medical staff. Policies with respect to the release of the bodies shall conform to local law.

II. Orders

A. Treatment Orders: All orders for treatment and diagnostic studies shall be in writing. (Written by the physician or a verbal/telephone order written by an RN or LVN)
    1. The above named individuals may only receive and record orders within their scope of practice.
    2. All verbal orders shall be signed by the person to whom the order was dictated and following the name of the physician dictating the order and shall be authenticated within 48 hours. Verbal orders may be received only from members of the medical staff with clinical privileges to do so and not from an office or clinic receptionist or nurse.
    3. Faxed orders with physician signatures may be accepted. Original faxes will be kept in the patient's medical record.

B. Time/Date: All Truckee Surgery Center orders shall be dated and timed. In addition, all Truckee Surgery Center personnel shall record the time when the order was transcribed.

C. Order Writing: All physicians' orders shall be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten and/or understood by the nurse.

D. Take Home Drugs: No drugs supplied by Truckee Surgery Center shall be taken from the surgery center.

III. Consents

A. No operation will be performed without the informed consent of the patient or his legal guardian except in documented emergencies. Appropriate informed consent for all anticipated procedures must be on the chart prior to surgery.

B. Informed Consent: It is the responsibility of the physician performing the procedure to obtain informed consent and to explain the potential risks and complications of the impending procedure and anesthesia. No preoperative medication will be given and the patient will remain in the preoperative area until the consent has been completed.

C. Content: The consent form must state the name of the physician and the name of the procedure or treatment. The physician is responsible to obtain the informed consent and it will be signed when the patient has been advised in simple terms of the risks, benefits and alternatives to surgical treatments or procedures.

D. Consent Manual: The Medical Staff of Truckee Surgery Center has adopted the California Hospital Association's Consent Manual to serve as operating policy governing all matters of consents.

E. Physicians shall see that one parent or guardian signs the consent for minors. The consent of both parents is recommended whenever possible.

F. A sterilization consent will be signed on all patients undergoing sterilization procedures as required by the Consent Manual.

IV. The Medical Record

A. Responsibility/Content: The admitting physician shall be responsible for a complete and legible medical record for each patient. This record shall contain current and pertinent information including Identification of the patient; admission history and physical exam; consultations; diagnostic records; operative reports; pathology findings; final diagnosis; and discharge condition.

B. Preoperative Requirements: All surgical patients must have a history and physical examination, appropriate lab and diagnostic tests and appropriate consultations prior to surgery. If the history and physical has been dictated but is not on the chart, the physician must indicate this and complete a note with pertinent physical findings, history and admitting diagnosis.

C. Admission History and Physical: An admission history and physical examination shall be recorded by the attending physician on or before the day of surgery, and include all pertinent findings.

1. When a complete history has been recorded and a physical examination performed within a week prior to the patient's surgery at Truckee Surgery Center, or when a patient is readmitted within thirty days of the last admission for the same or a related condition, a legible copy of these reports may be used in the medical record. In such instances, an interval admission note must be written addressing changes in the history or physical condition of the patient.
2. An acceptable history and physical includes: chief complaint; details of present illness; relevant past social and family history; review of systems; pertinent physical findings; current physical assessment; treatment plan.
3. If the history and physical was performed by a physician other than the physician performing the procedure, that physician must document his/her preoperative findings by way of dictated report or progress note prior to commencement of surgery.

D. Preoperative/Operative Note: The surgeon should record and authenticate a preoperative diagnosis prior to surgery in the medical record. An operative note must be written in the progress notes immediately after surgery and shall specify the type of operation performed and contain any other pertinent information.

E. Operative Report: Operative reports will include a detailed account of the findings during the procedure and the details of the surgical technique. Operative reports will be dictated within twenty-four hours following surgery and the report promptly signed by the physician and made part of the medical record. Reports not dictated within twenty-four hours of the procedure will be ground for temporary restriction of privileges.

F. Abbreviations: Abbreviations from the Dictionary of Medical Acronyms and Abbreviations are considered current. A copy of this book is kept in the Post Anesthesia Care Unit. Addendums will be kept with the book as required.

G. Release of Information: Written consent of the patient is required for release of medical Information to persons not otherwise authorized to receive the information.

H. Removal of Records: All medical records are the property of Truckee Surgery Center and may be removed from the surgery center's safekeeping only in accordance with a court order, subpoena or statue. Any physician removing charts from the surgery center will be immediately suspended.

I. Access to Medical Records: When a patient is readmitted to the surgery center, previous records will be available for the use of the admitting physician and anesthesiologist. Physicians shall not be allowed access to the medical records of other physician's patients unless:
   - It is an authorized study and research project approved by the Executive.Committee
   - They have been directed by the Executive Committee to review the medical record of another physician's patients
   - They are actively involved in the patient care
   - And/or the patient signs a release form.

J. Permanent File: The medical record will not be permanently filed until it is completed by the responsible physician.

K. Suspension for Incomplete Medical Records: All medical records will be completed within fourteen days of surgery/procedure.

L. Admissions While on Temporary Suspension: If a member of the medical staff has been notified according to established policies for delinquent records by a phone call from the Administrator and the physician has a surgery scheduled during the described period of suspension, the physician will be contacted at 9:00am the working day before the scheduled admission and asked to complete the medical records in question by 2:00pm or the procedure will be cancelled. The physician will be responsible for informing the patient regarding the cancellation. If the patient arrives at Truckee Surgery Center, the patient will be asked to contact his/her physician.

M. Alteration of a Medical Record: Unwanted entries should be lined through, signed and dated. Corrections should be entered in the record chronologically, signed and dated. Do not remove or obliterate entries or documents.

N. Inappropriate Chart Notes: Physicians are restricted from writing interpersonal comments that reflect upon the personality, Integrity or competence of any other physician in the patient record. Physicians who do so will be considered in violation of the Rules and Regulations and could be suspended from the Medical Staff.

0. Laboratory Tests Performed Outside Truckee Surgery Center: outside lab, test results may become part of the medical record only if such tests are performed in labs that have been certified by the College of American Pathologists or their equivalent or licensed through the Clinical Laboratories Improvement Act of 1967. Lab results not performed in such facilities may be referred to in the admission history and physical or progress notes.

V. Allied Health Professional

While not qualified for membership on the Medical Staff, allied health professionals may practice in Truckee Surgery Center under the following conditions:

A. Each person shall have sufficient training, experience and demonstrated competence to:
   - Exercise judgment within their area of competence.
   - Participate directly in the management of patients under the supervision or direction of a member of the medical staff, within the
   . limits established by the medical staff and consistent with state law. Entries to the medical record by· allied health professionals will be countersigned by the physician.

B. Each person will be under direct supervision of an attending physician. They may carry out their activities in conformity with Medical Staff Bylaws, Rules and Regulations and upon direct order of the attending physician.

C. Approval to practice in Truckee Surgery Center within the guidelines established above will be contingent upon recommendation of the Executive Committee and Governing Board.

VI. Access to Credentials Files

Each member in good standing of the medical staff of Truckee Surgery Center may have access to his credentials file. This review must be requested In advance and must be accomplished in the presence of the Medical Director or his/her designee. No member of the Medical Staff will be allowed access to the information contained in another staff member's file unless it is within the scope of committee activity related to peer review or privileging functions.

VII. Responding To Committee Inquiries

Medical staff members must respond within one month to a request from the Executive Committee, which has mailed return receipt requested, or be suspended from the staff until said response has been received or current medical staff appointment has expired.

Truckee Surgery Center
Anesthesia
Rules and Regulations

I. General Organization

Anesthesia is that membership of the medical staff that primarily concerns itself with the anesthesiology aspects of surgical and medical care, diagnosis and treatment.

II. Pre-Anesthesia

A. Preoperative Visit: The preoperative visit will be conducted by an anesthesiologist scheduled for the case prior to the scheduled surgery at which time there shall be a disclosure of the plan of anesthesia, the surgical procedure anticipated, the possible risk and possible complications and completion of the pre-anesthetic evaluation. It is expected that the anesthesiologist will make every effort to contact the patient by phone prior to the scheduled surgery day to decrease unexpected delays due to patient questions, complications, or additional required testing. Except in emergency cases, this evaluation will be recorded prior to the patient's transfer to the operating room. The choice of specific anesthetic agent or technique will be left to the discretion of the anesthesiologist.

B. Preoperative Evaluation: The preoperative evaluation will be documented in the patient's medical record and will include at least the following:
   - Pertinent history and physical exam
   - Airway examination
   - Choice of anesthesia
   - Other anesthesia experience
   - Potential anesthetic problem
   - Date and time of visit
   - ASA Classification for anesthetic risk

C. Preoperative Medication: Preoperative medications may be ordered by the anesthesiologist.

D. Responsibilities During Surgery: It is the responsibility of the anesthesiologist and the circulating nurse to identify the patient prior to entering the operating room and ascertain that the medical record contains the appropriate informed consent forms for the contemplated surgical procedures. The anesthesiologist is always directly responsible to the patient.
   - As a physician, the anesthesiologist is expected to use drugs he/she may deem advisable in a given situation.
   - Blood products are checked against the patient's ID, chart and administration slip by the anesthesiologist and circulating nurse. It is then started by the anesthesiologist who completes the appropriate documentation.
   - The anesthesiologist is in complete charge of all emergency procedures except those relating directly to surgery.
   - When appropriate, the IV fluids are started preoperatively in the pre- operative area by the nurse or anesthesiologist.

E. Presence of Anesthesiologist: The anesthesiologist shall be in constant attendance during the entire procedure and a record of all events taking place during the induction, maintenance and emergence from anesthesia, Including the dosage and duration, shall be maintained. This is not to preclude the induction of regional anesthesia in a designated holding area where continuous monitoring is available and used.

F. Administration: Anesthesia shall not be started on any surgical case until the surgeon is in Truckee Surgery Center. If the operating surgeon leaves the surgery center during a procedure the anesthesiologist will complete an occurrence report. The Medical Director and Administrator will be notified.

III. Local Anesthesia

A. Definition: Local anesthesia is defined as anesthetizing a specific area causing insensibility to pain.
B. Responsibility: If no anesthesiologist is present In the operating room, the surgeon will be responsible for the administration of the local anesthesia.
C. Drug and Equipment Availability: All usual drugs and necessary resuscitation equipment will be available and the physician in charge will be knowledgeable and proficient in their use.
D. Monitoring of Patient: During local anesthesia, in the absence of an anesthesiologist, vital signs will be monitored and recorded by a Registered Nurse. Medications may be given by the nurse on the order of a physician. ·

IV. Immediate Postoperative Period

The responsibility for patients in the PACU is shared by the surgeon, anesthesiologist and the PACU nurse.

A. The anesthesiologist will be responsible for the assessment of the post-anesthetic patient. He/she will determine the stability of the patient upon completion of the procedure and closely monitor the patient throughout the recovery period.
B. The anesthesiologist will remain available in the surgery center until the patient's condition is stable.
C. Discharge from the Recovery Room is to be by direct order from the anesthesiologist.
D. The patient's post-anesthesia status will be documented by the anesthesiologist in the medical record, dated and timed.

Truckee Surgery Center
Surgery
Rules and Regulations

I. General Organization

A. Composition: Surgery is that membership of the medical staff which concerns itself with the surgical aspect of the diagnosis and treatment of disease and. may include physicians with privileges in the following specialties: Dentistry and Oral Surgery, General Surgery, Ophthalmology, Orthopedics, Gynecology, Otolaryngology, Plastic and Reconstructive Surgery, Podiatry, Urology and Pain Management

II. Privileges

A. Monitors: Monitors are to be arranged by the applicant from members of the medical staff who have been granted the requested privileges. The monitoring physician is expected to complete a written record of the assessment.

III. General Rules and Regulations

A. Scheduling: Procedures may only be scheduled by members of the medical staff and in compliance with Truckee Surgery Center guidelines.
B. Provisional Surgical Privileges: Surgeons not yet approved for medical staff membership may be granted provisional surgical privileges.
C. Assistant Surgeons: It is the responsibility of the operating surgeon to arrange an appropriate assistant for cases at his/her discretion.
D. Outpatient Surgery: All patients must have their preoperative diagnostic tests completed the day prior to the scheduled procedure.
E. Surgery Start Time: Surgeons must be in the operating room and ready to begin at the scheduled time, unless there is a reasonable excuse for delay. A delayed case time may be assigned at the discretion of the anesthesiologist and the Charge Nurse.

IV. Conduct of Care

A. Visitors: See Operational Policy regarding visitors.
B. Wound Infections: It is requested that each surgeon or office nurse/representative report the presence of wound infections to the QAPI/IC Coordinator.

V. Pathology

A. Composition: Pathology is that membership of the Medical Staff, which primarily concerns itself with the anatomical pathology, surgical pathology and clinical pathology of medical care. Members shall be fully trained or Board Certified Clinical and Anatomical Pathologists.
B. Tissue and Foreign Objects: Tissues removed shall be delivered to the pathologist at the discretion of the surgeon and within the guidelines of the pathologists and operational policy entitled "Specimen Collection" A report of the pathologist's findings shall be filed in the medical record. The tissue will be the property of the surgery center/pathologist. Slides of tissue blocks may be made available to outside facilities at a doctor's request for review on a loan basis.

VI. Dentists and Oral Surgeons

A. Medical Appraisal: A patient admitted for dental care shall receive the same basic medical appraisal as patients admitted for other surgical procedures.

B. ~~Responsibility: A patient admitted for dental care carries a dual responsibility involving the dentist and physician member of the Medical Staff.~~Responsibility: A patient admitted for dental care is a dual responsibility involving the dentist and the patient's primary care provider or cardiologist (licensed MD/DO).

1. Dentists Responsibilities:
   - A detailed dental history addressing necessity and appropriateness of care.
   - A detailed description of the examination of the oral cavity and preoperative diagnosis.
   - A complete operative report, describing the findings and technique. In cases of teeth extractions, the dentist must report the number of teeth and fragments will be sent to the pathologist for examination.
   - Progress notes must be relevant to the oral condition.

2. Physician Responsibilities:
   - Medical history pertinent to the patient's general health, including consultation ~~requirements.~~requirements. Within 30 days of the planned procedure, completed by the patients primary care or cardiologist..
   - Medical Clearance, completed by the patient's primary care provider or cardiologist, for the patient to be admitted to the facility for the planned procedure.
   - A physical examination to determine the patient's condition prior to anesthesia and surgery, completed by the patient's primary care or cardiologist..
   - A pre-anesthesia evaluation by an anesthesiologist~~. For ASA class I, II, and stable III patients, this evaluation may serve as the physician history and physical exam.~~
   - Treatment of any medical condition present on admission or that occurs during the patient's stay at ~~Folsom~~ Truckee Surgery Center.

3. Discharge: The discharge of the dental patient will be on written order of the dentist member or the responsible physician member of the Medical Staff

4. History and Physical Requirements for Oral Surgeons: Physician responsibilities as described in the first two physician responsibilities above may be waived for qualified oral surgeons who, after appropriate monitoring, have been granted privileges to perform complete history ~~and physical~~and ~~examinations~~physical ~~on~~examinations ~~their~~on their patients.

VII. Podiatry

A. Medical Appraisal: A patient admitted for pediatric care shall receive the same basic medical appraisal as patients admitted for other surgical procedures.

B. Responsibility: A patient admitted for ~~pediatric~~ podiatric care ~~carries~~ is a dual responsibility involving the podiatrist and ~~physician member of the Medical Staff.~~the patient's primary care provider or cardiologist (licensed MD/DO).

1. Podiatrist's Responsibilities:
   - A detailed ~~pediatric~~podiatric history addressing necessity and appropriateness of care.
   - A detailed description of the examination of the foot and preoperative diagnosis.
   - A complete operative report, describing the findings and techniques.
   - Progress notes must be relevant to the pediatric condition.

2. Physician Responsibilities:
   - Medical history pertinent to the patient's general health, including consultation requirements. Within 30 days of the planned procedure, completed by the patients primary care or cardiologist.
   - Medical Clearance, completed by the patient's primary care provider or cardiologist, for the patient to be admitted to the facility for the planned procedure.
   - ~~requirements.~~
   - A physical examination to determine the patient's condition prior to

anesthesia and surgery, completed by the patient's primary care or cardiologist.~~.~~

- ~~•~~A pre-anesthesia evaluation by an anesthesiologist~~. For ASA class I, II, and stable III patients, this evaluation may serve as the physician history and physical exam.~~
- Treatment of any medical condition present on admission or that occurs during the patient's stay at Truckee Surgery Center.

3. Discharge: The discharge of a podiatric patient will be on the written order of the podiatric member of the medical staff and responsible physician.

~~Treatment of any medical condition present on admission or that occurs during the patient's stay at Truckee Surgery Center.~~
~~Discharge: The discharge of a podiatric patient will be on the written order of the podiatric member of the Medical Staff and countersigned by the responsible physician.~~

TRUCKEE SURGERY CENTER, LLC
Department of Surgery

Delineated Clinical Privilege Request

SPECIALTY: PODIATRY **NAME:**_____
Please print

Application for privileges at Truckee Surgery Center (TSC, LLC)

Check One: ☐ **Initial** ☐ **Change in Privileges** ☐ **Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education:	DPM
Minimum Formal Training:	**Category A:** Two years of CPME-approved residency training (at least 12 months in surgical residency) Board qualified or certified in foot surgery (ABPS) or American Board of Multiple Specialties in Podiatry (ABMSP) or **Category B:** Three years of CPME-approved residency (at least 24 months in surgical residency), or two years supplemented by fellowship training. Board qualified or certified in reconstructive rearfoot/ankle surgery, ABPS.
Board Certification:	Board qualification or Certification required in Podiatry Surgery (American Board of Multiple Specialties in Podiatry or American Board of Podiatric Surgery) within five years of completion of training program.
Required Previous Experience: (required for new applicants)	• Applicant must be able to document that he/she has managed 15 patients in the past 2 years. • Recent residency training may be applicable. • If training has been completed within the past 5 years, documentation shall be requested from the program director attesting to your competency in the privileges requested including residency log. • If training has been completed greater than 5 years ago, documentation will be requested from the chairman of the department at the facility where you have maintained active staff privileges attesting to your competency in the privileges requested.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another facility where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competency, ethical character and ability to work with others. (At least one peer reference must be a podiatrist.) Medical Staff Office will request information
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring and evaluation may be required if a minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA. • Current, unrestricted DEA certificate. • Malpractice insurance in the amount of $1m/$3m. • Ability to participate in federally funded programs (Medicare or Medicaid).

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competency.

Any applicants who held the following privileges prior to the revision date are grandfathered for those privileges; however, all applicants must meet any new criteria defined for maintaining privileges (at reappointment).

TRUCKEE SURGERY CENTER, LLC

Department of Surgery – Podiatry

Name:_____

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of cases treated during the past 24 months. **Privileges are available at TSC, LLC and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

Recommending individual/department must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

REQUESTED	APPROVED	GENERAL PRIVILEGES – PODIATRY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required
A patient admitted for podiatric care is a dual responsibility involving the podiatrist ~~and a physician member of the Medical Staff.~~and the patient's primary care provider or cardiologist (licensed MD/DO who has completed the medical portion of the H&P exam, clearing the patient for the planned surgical procedure within 30 days of facility admission. (a) Podiatrist responsibilities: (1) A detailed podiatric history justifying the facility admission. (2) A detailed description of the examination of the lower extremity and a pre-operative diagnosis. (3) A complete operative report, describing the findings and technique. (4) Progress notes pertinent to the podiatric condition. (5) Clinical resume statement at the time of discharge.						
☐	☐	**CATEGORY A** Basic privileges include the co-admission, diagnosis, medical, surgical, mechanical, manipulative, consultation, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the non surgical treatment of muscles and tendons of the leg governing the functions of the foot. (Section 2472 of the Medical Practice Act). Basic privileges also include the performance of procedures in the following areas: • Capsulotomy/Tenotomy Digital M-P Joints • Digital Surgery • Osteotomy & Ostectomy • Soft Tissue Repairs & Excisions - Digits & Forefoot • Fractures of Digits & Metatarsals – (ORIF or Closed) • Bunionectomy • Bunionectomy with Osteotomy • Prosthesis of Great Toe Joint, lesser toe joints • Metatarsal Osteotomy & Ostectomies • Excision of Soft Tissue Neoplasms, Foot • Fasciotomy, Plantar (Simple, Steindler) • Midfoot Osteotomies & Arthrodesis) • Ostectomies of the Midfoot & Rearfoot • Neurolysis of the Foot • Amputations of the Digits & Forefoot • Fractures of the Forefoot & Midfoot (ORIF or Closed) • Forefoot Arthroplasty - Head/Base Excisions • Osteomyelitis Management of the Forefoot and midfoot • Bone Graft Harvest from Foot • I&D, Debridement of Foot infections	_____	TSC, LLC	First case proctored and 4 add'l cases of various procedures	10 cases in 2 years Inpatient or outpatient

TRUCKEE SURGERY CENTER, LLC

Department of Surgery – Podiatry **Name:**_____

REQUESTED	APPROVED	SELECTED PROCEDURES These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria
☐	☐	**CATEGORY B** (initial and cross out those you are not requesting) Rearfoot and ankle Privileges include the admission, diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the non surgical treatment of the muscles and tendons of the leg governing the functions of the foot. (Section 2472 of the Medical Practice Act) Rearfoot and Ankle • Flatfoot Reconstruction with Osteotomy, Bone Grafts, etc. • Cavus Foot Reconstruction with Osteotomy, Fusions, etc. • Major Tendon Transfers Lengthening & Repair of the Foot & Leg • Ligmentoplastic Repair or Ankle Stabilization • Arthroereisis, with Implants, Hindfoot & Ankle • Major Rearfoot Arthrodesis - Triple, Subtalar • Fractures of the Rearfoot - Tarsals (ORIF & Closed Reductions) • Ankle Fractures (ORIF & Closed Reductions) • Ankle Arthrodesis • Osteomyelitis Management - Hindfoot, Ankle • Flaps/Skin Grafts • I&D, Debridement of Foot & Ankle Infections • Neurolysis and Neurectomy of the Ankle • Excision of Soft Tissue Neoplasms • Clubfoot and Vertical Talus Release/Reconstruction • Hindfoot & Ankle Osteotomies & Cartilage Repair • Foot and Ankle, Arthroscopy (Diagnostic/Surgical) • Excision of Malignant Neoplasms of the Foot and Ankle • Amputations – Midfoot • Osteotomy – Ankle • Release of nerve entrapment		TSC, LLC	First case proctored and 4 others of various procedures	10 cases in 2 years Inpatient or outpatient
☐	☐	Intravenous Procedural Sedation (see attached credentialing criteria)	NA		Take and pass the test	Maintain privileges requiring this procedure
☐	☐	Fluoroscopy Submit copy of current Department of Health Services fluoroscopy certificate	_____		None	Maintain current certificate
☐	☐	Treatment of vascular conditions using injection, laser, electrosurgical or surgical excision Documentation of training and/or experience required for consideration	_____		2 cases	2 cases
☐	☐	Surgical Assisting: May assist MD or DO	_____		0	0

TRUCKEE SURGERY CENTER, LLC

Department of Surgery – Podiatry

Name:_____

		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medical Staff Office and will be forwarded to the appropriate review Committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of their license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of TSC, LLC and its medical staff.

_____ _____

Date Applicant's Signature

MEDICAL DIRECTOR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the applicant be granted:

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)

_____ _____

Date Medical Director Signature

Modifications or Other Comments:

_____

_____

_____

MEC:_____ (date of Committee review/recommendation)

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)

BOARD OF MANAGERS:_____(date of Board review/action)

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)

TRUCKEE SURGERY CENTER, LLC
Department of Surgery

Delineated Clinical Privilege Request

SPECIALTY: GENERAL DENTISTRY **NAME:**_____
Please print

Application for privileges at Truckee Surgery Center, LLC (TSC, LLC)

Check One: ☐ **Initial** ☐ **Change in Privileges** ☐ **Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education:	DDS, DMD
Minimum Formal Training:	Applicant must have graduated from a dental school recognized by the American Dental Association
Required Previous Experience: (required for new applicants)	• Applicant must be able to document that he/she has managed at least 10 dental inpatient, outpatient, emergency service, or consultative procedures in the past 24 months. • Recent post doctoral training experience may be applicable. • If training has been completed within the past 5 years, documentation shall be requested from the program director attesting to your competency in the privileges requested including program log. • If training was completed greater than 5 years ago, documentation shall be requested from the chairman of the department at the facility where you have maintained active staff privileges attesting to your competency in the privileges requested.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another facility where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competency, ethical character and ability to work with others. At least one peer reference must be a DDS or DMD. Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring and evaluation may be required if a minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA. • Malpractice insurance in the amount of $1m/$3m. • Current, unrestricted DEA certificate in CA (approved for all drug schedules). • Current State Pharmacy Certificate. • Ability to participate in federally funded programs (Medicare or Medicaid).

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competency.

Any applicants who held the following privileges prior to the revision date are grandfathered for those privileges; however, all applicants must meet any new criteria defined for maintaining privileges (at reappointment) including Board maintenance or recertification for those applicants who have been on the medical staff less than 15 years.

TRUCKEE SURGERY CENTER, LLC

Department of Surgery – General Dentistry Name:_____

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of cases treated during the past 24 months. P**rivileges are available at TSC, LLC and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

Recommending individual/Committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

REQUESTED	APPROVED	GENERAL PRIVILEGES – GENERAL DENTISTRY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus additional cases at discretion of proctor	Reappointment Criteria Based on current demonstrated competency and provision of care. Insufficient activity may require proctoring and/or additional CME~~E~~
		A patient admitted for dental care is a dual responsibility involving the dentist and the patient's primary care provider or cardiologist (licensed MD/DO who has completed the medical portion of the H&P exam, clearing the patient for the planned surgical procedure within 30 days of facility admission.				

☐	☐	**Basic privileges in General Dentistry**:
		• History and Physical examinations related to dental information. Co-admitting ~~with a physician member of the medical staff required.~~with a licensed MD/DO who has completed the medical H&P, clearing the patient for the planned dental procedure.
		• Basic privileges include ability to evaluate total oral health needs, work up and provide comprehensive general dental diagnostic, preventative, consultative, refer patients to appropriate specialists while preserving continuing care, and therapeutic oral health care to patients of all ages to correct or treat various routine conditions of the oral cavity. Basic privileges include:
		  • Manage extremely fearful patients
		  • Minor oral surgery
		  • Simple removal of teeth
		  • Complicated removal of teeth
		  • Alveolectomy, alveoloplasty, alveolotomy
		  • Prosthetic replacement of teeth
		  • Prosthetics
		  • Pathology
		  • Intraoral incision and drainage of minor infections
		  • Minor biopsies
		  • Root canal therapy
		  • Restorative Dentistry
		  • Operative restorations
		  • Crown or bridge preparation
		  • Trauma
		  • Reimplantation and stabilization of avulsed and/or subluxated teeth
		  • Repair of minor intraoral lacerations
			_____	TSC, LLC	First case proctored and 4 additional representative cases proctored	100 cases/2 years
						Related CME

TRUCKEE SURGERY CENTER, LLC

Department of Surgery – General Dentistry **Name:**_____

REQUESTED	APPROVED	GENERAL PRIVILEGES – GENERAL DENTISTRY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus additional cases at discretion of proctor	Reappointment Criteria Based on current demonstrated competency and provision of care. Insufficient activity may require proctoring and/or additional CME
		A patient admitted for dental care is a dual responsibility involving the dentist and the patient's primary care provider or cardiologist (licensed MD/DO who has completed the medical portion of the H&P exam, clearing the patient for the planned surgical procedure within 30 days of facility admission.				
☐	☐	REMOVAL FROM BASIC PRIVILEGES: Should applicant's current practice limitations or current competency exclude performance of any privileges specified in the l basic privileges listed above, please indicate here. Applicant and/or the Medical Executive Committee (MEC) must document reasons for exclusion. **If extensive list of exclusions, initial and cross out above.** _____ _ _____ _ _____ _ _____ _				

REQUESTED	APPROVED	SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.** **In those areas with multiple procedures, initial and cross out those you are NOT requesting**	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus additional cases at discretion of proctor	Reappointment Criteria Based on current demonstrated competency and provision of care. Insufficient activity may require proctoring and/or required CME
☐	☐	**Intravenous Procedural Sedation** (see attached credentialing criteria)	N/A	TSC, LLC	Successful completion of competency test (initial appointment)	Maintain privileges requiring this procedure
☐	☐	Open or closed reduction of fractures of jaw or related structures Documentation required of training and/or experience	_____	TSC, LLC	1 case proctored	1 case/2 years of proctoring required
☐	☐	Periodontal Surgery Documentation required of training and recent experience	_____	TSC, LLC	1 case proctored	1 case/2 years of proctoring required

TRUCKEE SURGERY CENTER, LLC

Department of Surgery – General Dentistry Name:_____

☐	☐	Dental implant surgery Documentation required of training and recent experience	_____	TSC, LLC	1 case proctored	1 case/2 years of proctoring required
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medical Staff Office and will be forwarded to the appropriate review Committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of their license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of TSC, LLC and its medical staff.

_____ _____
Date Applicant's Signature

MEDICAL DIRECTOR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the applicant be granted:

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)

_____ _____
Date Medical Director Signature

Modifications or Other Comments:

_____

_____

_____

MEC:_____ (date of Committee review/recommendation)

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)

BOARD OF MANAGERS:_____(date of Board review/action)

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)

Truckee Surgery Center

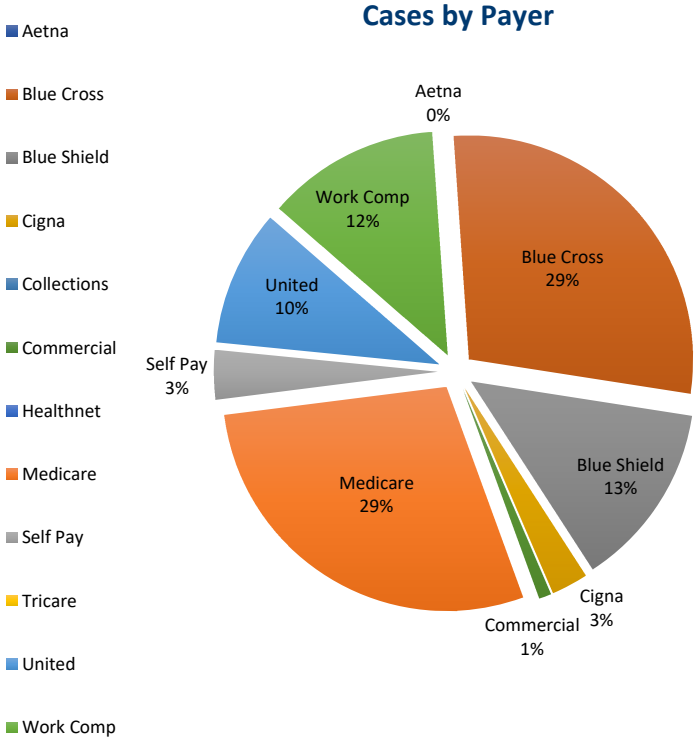
Monthly Comparison & Quarterly Totals

As of Mar 31, 2020

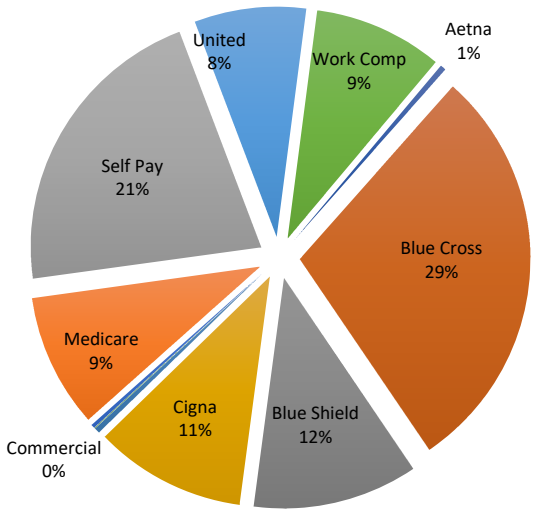
Cases and Collections by Payer

	Jan 2020			Feb 2020			Mar 2020			1st Quarter 2020		
Payer	**Cases**	**Collections**	**% Total**	**Cases**	**Collections**	**% Total**	**Cases**	**Collections**	**% Total**	**Cases**	**Collections**	**% Total**
Aetna	0	$1,017.08	1.75%	0	$0.00	0.00%	0	$0.00	0.00%	0	$1,017.08	0.4%
Blue Cross	7	$15,511.47	26.65%	15	$20,586.19	33.31%	10	$35,024.56	27.95%	32	$71,122.22	29.0%
Blue Shield	2	$8,887.52	15.27%	10	$4,561.18	7.38%	3	$14,946.46	11.93%	15	$28,395.16	11.6%
Cigna	0	$0.00	0.00%	3	$0.00	0.00%	0	$26,087.73	20.82%	3	$26,087.73	10.6%
Collections	0	$961.53	1.65%	0	$0.00	0.00%	0	$0.00	0.00%	0	$961.53	0.4%
Commercial	0	$0.00	0.00%	0	$0.00	0.00%	1	$93.92	0.07%	1	$93.92	0.0%
Healthnet	0	$643.25	1.11%	0	$0.00	0.00%	0	$0.00	0.00%	0	$643.25	0.3%
Medicare	12	$4,273.54	7.34%	11	$8,033.70	13.00%	9	$10,711.54	8.55%	32	$23,018.78	9.4%
Self Pay	0	$7,623.03	13.10%	4	$18,262.02	29.55%	0	$26,624.69	21.25%	4	$52,509.74	21.4%
Tricare	0	$0.00	0.00%	0	$0.00	0.00%	0	$0.00	0.00%	0	$0.00	0.0%
United	4	$5,242.62	9.01%	2	$2,620.26	4.24%	5	$11,385.59	9.09%	11	$19,248.47	7.8%
Work Comp	3	$14,036.57	24.12%	1	$7,737.12	12.52%	10	$426.47	0.34%	14	$22,200.16	9.1%
Painblocks	0	$0.00	0.00%	0	$0.00	0.00%	0	$0.00	0.00%	0	$0.00	0.0%
Totals	***28***	***$58,196.61***		***46***	***$61,800.47***		***38***	***$125,300.96***		***112***	***$245,298.04***	

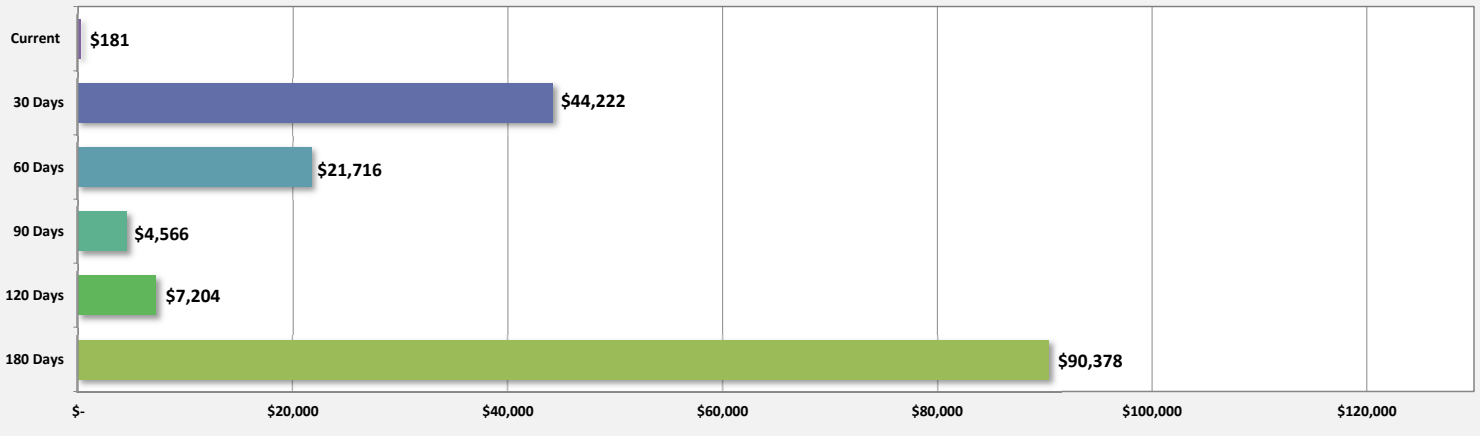
Cases by Payer



Collections by Payer



Accounts Receivable Aging



Truckee Surgery Center

Monthly Comparison & Quarterly Totals

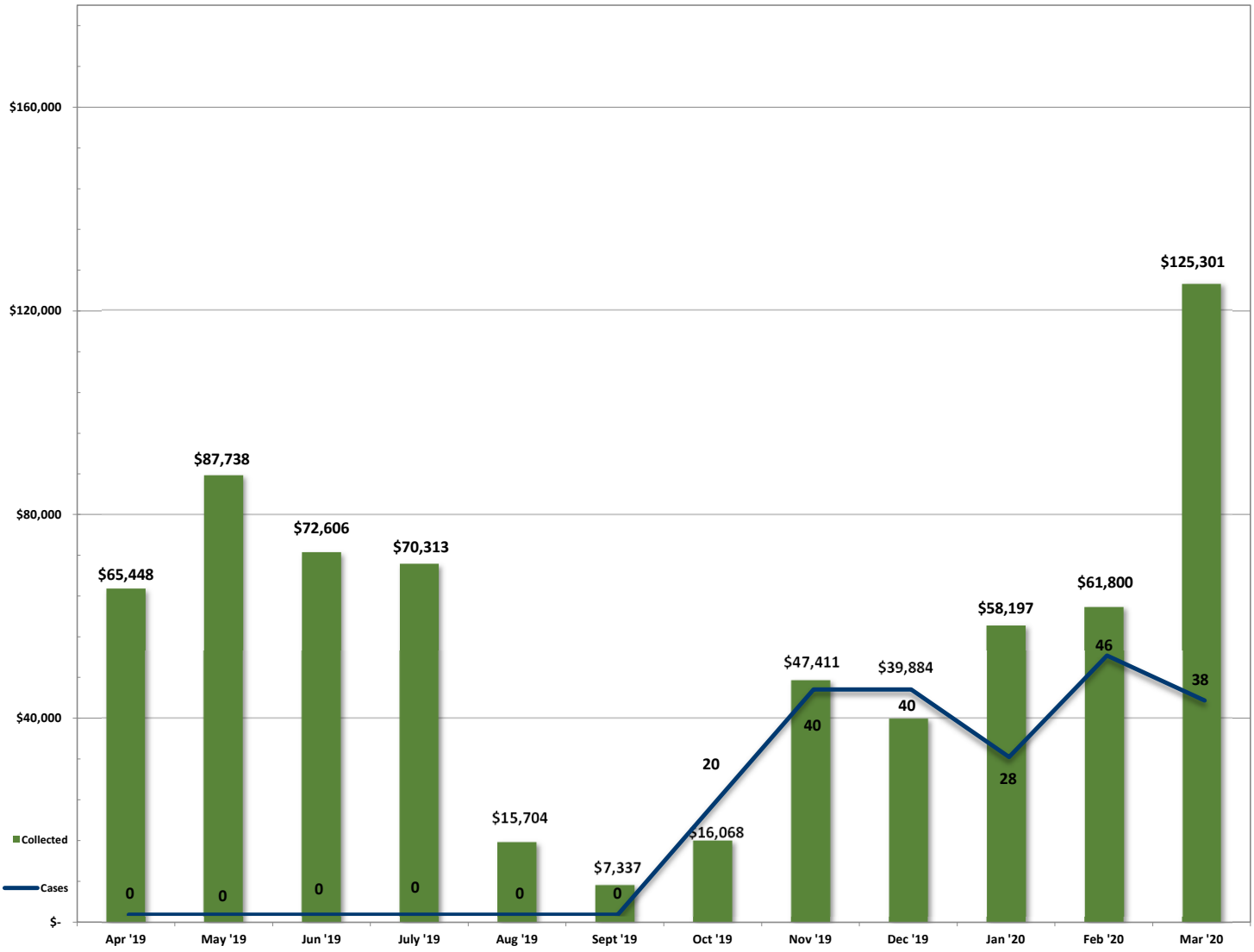
As of Mar 31, 2020

Cases and Revenue by Physician

	4th Quarter 2019					1st Quarter 2020				
Physician	**Cases**	**% Total**	**Net Revenue**	**% Total**	**Rev/Case**	**Cases**	**% Total**	**Net Revenue**	**% Total**	**Rev/Case**
Condon	1	1.0%	$ 1,082.00	0.6%	$1,082.00	2	1.8%	$ 4,369.25	1.9%	$2,184.63
Dickinson	0	0.0%	$ -	0.0%	$0.00	0	0.0%	$ -	0.0%	$0.00
Dodd	15	15.0%	$ 42,572.56	25.5%	$2,838.17	20	17.9%	$ 76,899.45	33.6%	$3,844.97
Foley	0	0.0%	$ -	0.0%	$0.00	0	0.0%	$ -	0.0%	$0.00
Ganong	34	34.0%	$ 27,022.86	15.9%	$781.11	22	19.6%	$ 15,893.42	6.9%	$722.43
Haeder	5	5.0%	$ 15,778.22	3.1%	$1,045.10	11	9.8%	$ 28,987.45	12.7%	$2,635.22
Hagen	8	8.0%	$ 29,018.94	17.4%	$3,627.37	6	5.4%	$ 4,703.49	2.1%	$783.92
Ringnes	28	28.0%	$ 78,024.76	37.5%	$2,234.83	25	22.3%	$ 95,124.18	41.5%	$3,804.97
Saaremets	1	1.0%	$ -	0.0%	$0.00	2	1.8%	$ -	0.0%	$0.00
Wainstein	0	0.0%	$ -	0.0%	$0.00	3	2.7%	$ 2,965.61	1.3%	$988.54
Painblocks	8	8.0%	$ -	0.0%	$0.00	21	18.8%	$ -	0.0%	$0.00
Totals	***100***		***$ 193,499.34***		***$1,934.99***	***112***		***$ 228,942.85***		***$2,044.13***

s - Rolling 12 Months

Collection Min	Collection Max	Collection Average	Cases Min	Cases Max	Cases Average
$7,337.02	$125,300.96	$55,650.65	0	46	18



Truckee Surgery Center

Monthly Comparison & Quarterly Totals

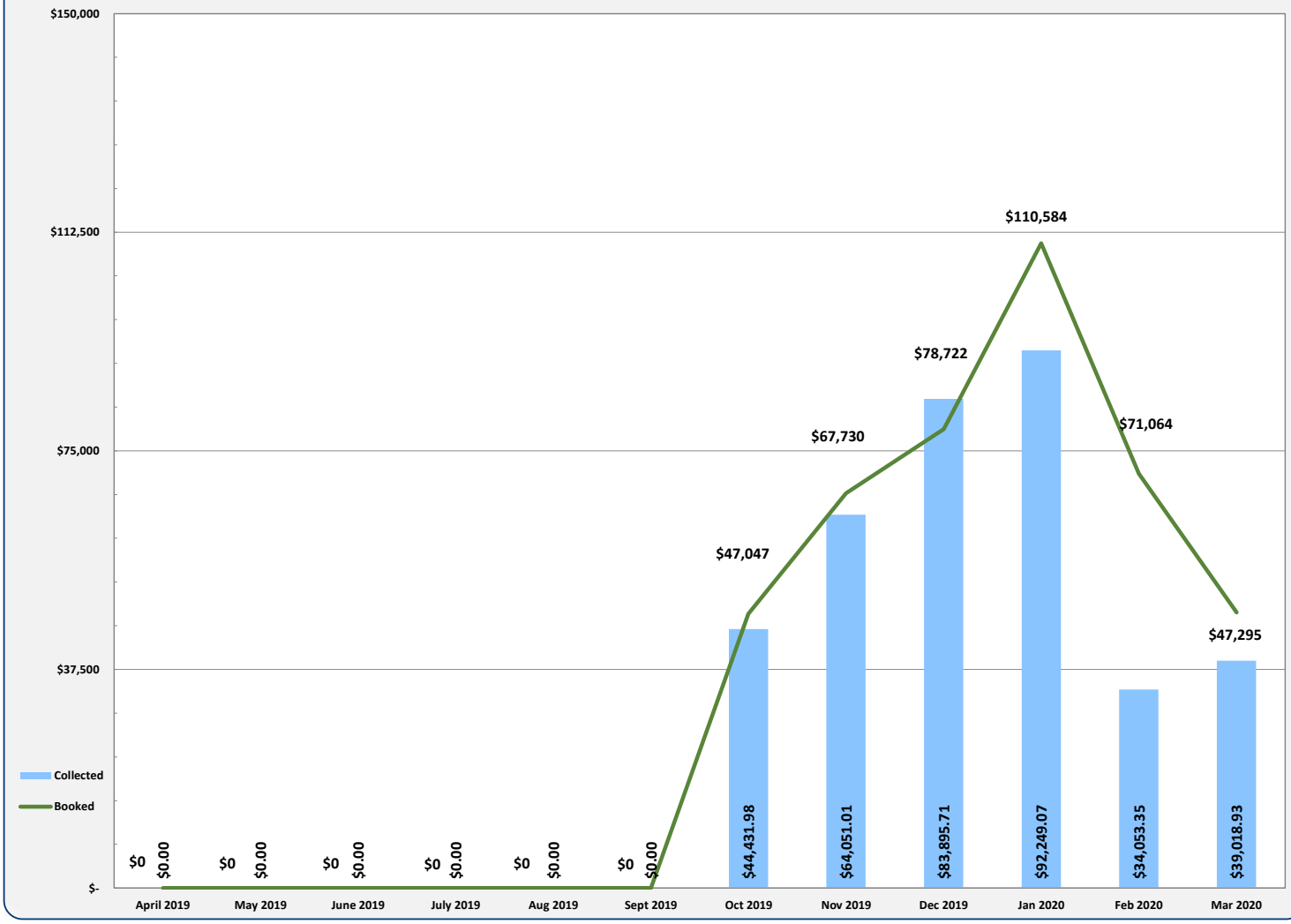
As of Mar 31, 2020

Revenue - Booked vs Collected

Month	Cases	Revenue	Rev/Case	Open A/R	% Open	Collected	% Collected
April 2019	0	$0.00	$0.00	$0.00	0%	$0.00	0%
May 2019	0	$0.00	$0.00	$0.00	0%	$0.00	0%
June 2019	0	$0.00	$0.00	$0.00	0%	$0.00	0%
July 2019	0	$0.00	$0.00	$0.00	0%	$0.00	0%
Aug 2019	0	$0.00	$0.00	$0.00	0%	$0.00	0%
Sept 2019	0	$0.00	$0.00	$0.00	0%	$0.00	0%
Oct 2019	20	$47,047.33	$2,352.37	$1,101.35	2%	$44,431.98	94%
Nov 2019	40	$67,730.35	$1,693.26	$5,712.35	8%	$64,051.01	95%
Dec 2019	40	$78,721.66	$1,968.04	($3,565.74)	-5%	$83,895.71	107%
Jan 2020	46	$110,583.64	$2,403.99	$18,420.44	17%	$92,249.07	83%
Feb 2020	38	$71,064.18	$1,870.11	$37,010.81	52%	$34,053.35	48%
Mar 2020	28	$47,295.03	$1,689.11	$8,720.71	18%	$39,018.93	83%
Totals	***212***	***$422,442.19***	***$1,992.65***	***$67,399.92***	***16%***	***$357,700.05***	***85%***

1st Quarter QuickFacts

- Cases: 112
- Revenue: ***$228,942.90***
- Collections: $245,298.04
- Outstanding Physician: Ringnes 22.3% of cases, 41.5% of revenue
- Outstanding Payer: Self Pay 3.57% of cases. 21.4% of collections



Truckee Projects & Changes

~ Quarterly Updates ~

No DOS cases in Q2 or Q3