GOVERNANCE DOCUMENT DEFINING THE ROLE OF THE BOARD OF SUPERVISORS CONCERNING GOVERNANCE OF ARROWHEAD REGIONAL MEDICAL CENTER
EFFECTIVE:

TABLE OF CONTENTS

PREAMBLE

Each hospital is required to have an effective governing body that is legally responsible for the conduct of the hospital. The Board of Supervisors of the County of San Bernardino (the Board) acts as the Governing Body of the Arrowhead Regional Medical Center (Medical Center). The Board hereby finds and determines:

1. The Medical Center is fully accredited by and in good standing with its accrediting organization

2. That the Centers for Medicare and Medicaid Services (CMS) has issued Conditions of Participation (COP) for Hospitals (42 C.F.R. Part 482 et. seq.), which set forth certification standards for participation in the Medicare program.

3. That the California State Licensing provisions for Health Facilities set forth the requirements for licensing of General Acute Care Hospitals and County Medical Facilities. (Health & Safety Code §§ 1250, 1440, 1441; and 22 Cal. Code Reg. Div. 5, Chap 1, Sections 70005 et. seq.)

4. That each of these regulatory agencies requires there be an effective governing body legally responsible for the conduct of the hospital and "Governance Bylaws" or similar documents (Governance Plan) that define the Governing Body's responsibility for Hospital operations.

These Governing Body Bylaws are hereby adopted to comply with the requirements of its accrediting organization and other State and Federal requirements and to provide a framework for governance of the Medical Center's operations and the Governing Body's relationship with the organized Medical Staff and applicants to the Medical Staff.

ARTICLE I
GENERAL RESPONSIBILITIES

1.1 Governing Body Bylaws

The Board shall adopt and review Governing Body Bylaws, as necessary.

1.2 Institutional Plan and Budget

1.2.1 An Institutional Plan and Budget must be prepared under the direction of the Governing Body, by the Joint Conference Committee, as discussed in Art. IX below.

1.2.2 The Institutional Plan and Budget consists of an annual operating budget that is prepared according to generally accepted accounting principles and identifies all anticipated income and expenses. It must include capital expenditures for at least a three (3) year period, including the year in which the operating budget is applicable, and must identify in detail the objective of, and the anticipated sources of financing in excess of $600,000 that relates to acquisition or improvement of land; or improvement, replacement, modernization, and expansion of buildings and equipment.

1.2.3 The Institutional Plan and Budget should include the Medical Center's mission statement as adopted by the Governing Body and the scope of services provided.

1.2.4 The Institutional Plan and Budget should also include mechanisms for planning and for assessing and improving the structure, processes, and outcomes of services and care, and for participation in planning to meet the health needs of the community.

1.2.5 The Institutional Plan and Budget shall also include appropriate mechanisms, delegations and funding to assure that a complete and accurate medical record is prepared and maintained for each patient.

1.2.6 The Institutional Plan and Budget must be updated annually and submitted for review to the Office of Statewide Health Planning and Development (OSHPD) pursuant to § 1122(b) of the Social Security Act.

1.3 Fiscal Accounting System

The Governing Body must ensure that the Medical Center has implemented an effective fiscal accounting system(s).

1.4 Adequacy of Physical Plant

The Governing Body is responsible for providing a physical environment that is constructed, arranged, maintained, equipped, and staffed to meet the needs and services required for patients. The Governing Body shall assure that all reasonable steps are taken to conform to all applicable federal, state, and local laws and regulations, including those

relating to licensure, fire inspection, and other safety measures. Written reports, from both internal and external sources, about the adequacy and deficiencies of the physical environment must be received and reviewed periodically.

1.5 Adequacy of Resources

The Governing Body is responsible for the provision of adequate resources to implement the programs of service. This will include an evaluation of services provided, including:

1. An evaluation of all organized services including services furnished by a contractor. Consequently, a list of all contracted services, with the scope and nature of such service, must be maintained by the Compliance Department and updated at least annually. The Governing Body must ensure that services performed under contract are provided in a safe and effective manner.

ARTICLE II
MEDICAL STAFF

2.1 Organized Medical Staff

The Governing Body is responsible for the organized Medical Staff, which, in turn, is accountable to the Governing Body for the quality of care provided to patients at MEDICAL CENTER. The Medical Staff shall adopt bylaws (the Medical Staff Bylaws), which, among other things, shall describe the organization of the Medical Staff and the officers that are to be appointed. The Medical Staff Bylaws and the Medical Staff Rules and Regulations must be reviewed by the Governing Body and are subject to Governing Body approval, which approval shall not be unreasonably withheld. The Medical Staff Bylaws shall comply with California and Federal law and the Medicare Conditions of Participation for Hospitals.

The Governing Body shall ensure that processes are established to facilitate communication between the Governing Body, Medical Center Administration, and the Medical Staff. The Governing Body shall consult directly with the individual assigned the responsibility for the organization and the Medical Staff, or his or her designee. This direct consultation shall occur periodically throughout the fiscal or calendar year and include discussion of matters related to the quality of medical care provided to patients of the Medical Center. The Governing Body should seek input from the Medical Staff regarding decisions of the Governing Body that impact the Medical Staff, except with regard to those policies and procedures that affect the Medical Center or County staff generally.

The Medical Staff shall be self-governed with respect to the professional work performed by the Medical Staff at the Medical Center and meet on a periodic basis to review and analyze at regular intervals their clinical experience. The medical records of the patients treated shall be the basis for such review and analysis.

2.2 Appointment and Reappointment of Medical Staff

2.2.1 Categories of Practitioners

The Governing Body shall determine which categories of practitioners are eligible candidates for appointment to the Medical Staff in accordance with applicable laws and regulations. These categories, along with the qualifications necessary for appointment to the Medical Staff, shall be designated and described in the Medical Staff Bylaws, which are subject to approval by the Governing Body.

2.2.2 Granting a Practitioner Privileges

The Governing Body shall have the sole authority to grant a practitioner Medical Staff membership and/or clinical privileges to provide care to patients at the Medical Center; provided, however, the Governing Body delegates to the Director of the Medical Center the right to grant Temporary Privileges (as such privileges are defined in the Medical Staff Bylaws) in accordance with and to the extent permitted by the guidelines and policies and procedures set forth in the Medical Staff Bylaws. The Governing Body also delegates to the Medical Director of the Medical Center the authority to grant Temporary Privileges to the same extent as the Director of the Medical Center as an authorized designee of the Director of the Medical Center. The procedures for appointment and reappointment to the Medical Staff and the granting of clinical privileges, including Temporary Privileges, are set forth in the Medical Staff Bylaws. The criteria for appointment and reappointment shall include individual character, competence, training and experience. Under no circumstances shall the grant of Medical Staff membership or specific clinical privileges be dependent solely upon certification, fellowship, or membership in a specialty body or society.

2.2.3 Action by the Governing Body

Upon receipt of the recommendation from the Medical Staff, the Governing Body may adopt, reject, or modify the recommendation, or may refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond. If the Governing Body's action is grounds for a fair hearing as outlined in the Medical Staff Bylaws, the applicant shall be entitled to the procedural rights as provided in the Medical Staff Bylaws and these Governing Body Bylaws.

2.2.4 Action Following Exhaustion of Hearing Rights

If any action by the Governing Body provides an applicant with a right to a fair hearing pursuant to the Medical Staff Bylaws, within sixty (60) days after an applicant's fair hearing rights have been exhausted or waived by the applicant, the Governing Body shall take final action in the matter. The Governing Body shall make a decision to either provisionally appoint the applicant or reject the application for Medical Staff membership and/or clinical privileges. The Governing Body's decision shall be conclusive.

2.3 Peer Review

2.3.1

Role of the Governing Body

The Legislature has determined that the Governing Body has a legitimate function in the peer review process. However, in all peer review matters, the Governing Body shall give great weight to the actions of the peer review bodies at the medical Center and, in no event, shall act in an arbitrary or capricious manner. The Governing Body shall act exclusively in the interest of maintaining and enhancing quality patient care at and as delivered by the Medical Center.

2.3.2 Failure of the Peer Review Body to Investigate or Take Disciplinary Action

In those instances in which the peer review body's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the Governing Body shall have the authority to direct the Medical Executive Committee and/or other peer review body to initiate an investigation or a disciplinary action, but only after consultation with the Medical Executive Committee. No such action shall be taken by the Governing Body in an unreasonable manner.

In those instances in which the Medical Executive Committee or another peer review body fails to take action in response to a direction from the Governing Body, the Governing Body shall have the authority to take action against a practitioner. Such action shall only be taken after written notice to the Medical Executive Committee and shall fully comply with the procedures and rules applicable to peer review proceedings at the Medical Center and any applicable laws, rules, and regulations.

2.3.3 Recommendation of the Medical Executive Committee

If corrective action, or termination of the peer review investigative process, is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body shall give great weight to the Medical Executive Committee's decision and initiate further action only if the failure to act by the Medical Executive Committee is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Committee and the Medical Executive Committee still has not acted. The recommendation shall become final if the Governing Body affirms it.

2.4 Immediate Corrective Action

The Governing Body, Director of the Medical Center or its designee, may immediately suspend or restrict a member's privileges if a failure to suspend or restrict those privileges is likely to result in an imminent danger to the health of any person, provided that the Governing Body, Director of the Medical Center, or designee has made reasonable attempts to contact the President of the Medical Staff, members of the Medical Executive Committee, and the Chairman of the Department (or designee) before the suspension, and those individuals were not available to summarily suspend or restrict clinical privileges in the circumstances contemplated by this Section 2.4. Such a suspension by the Governing Body, Director of the Medical Center or designee is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically.

ARTICLE III
FAIR HEARING AND APPELLATE REVIEW PROCEDURE

3.1 Process to Challenge Actions Not Reportable to Licensing Board

3.1.1 Notice to the Governing Body

If the action or recommended action was made by the Governing Body, a practitioner who is adversely and significantly affected by a quasi-judicial action or recommended action for which a review process is not otherwise provided in the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or otherwise pursuant to Medical Staff policies, and which is not reportable to a licensing board under Business and Professions Code Section 805, may contest such actions or recommended actions by delivering a written request for review to the Governing Body. Any such request for review must be delivered within thirty (30) days from the practitioner's receipt of notice of the action or recommendation. Upon receipt of such a request for review, the Governing Body shall afford the practitioner such review rights as the Governing Body may deem appropriate. Such review rights shall include notice of the reasons for the action or recommendation, a reasonable opportunity to respond, and resolution of the matter by an unbiased panel.

3.1.2 Types of Reviewable Matters

Examples of matters reviewable under this Section 3.1 include, without limitation, restriction of clinical privileges for less than thirty (30) days in a twelve (12) month period, suspension of clinical privileges for fourteen (14) days or less, and termination, denial, or restriction of clinical privileges or Medical Staff membership rights for reasons other than a medical disciplinary cause as defined in Business and Professions Code Section 805.

3.2 Process to Challenge Adverse Actions Reportable to Licensing Board

3.2.1 Preparation for Hearing

An action or final recommended action that must be reported to the appropriate licensing board constitutes grounds for a hearing. In the event of such an action or recommended action, a practitioner shall have the procedural rights to a hearing and appellate review as described in the Medical Staff Bylaws and these Governing Body Bylaws.

3.2.2 Appellate Review

In accordance with and subject to the procedures and requirements set forth in the Medical Staff Bylaws, either the person who requested the hearing or the body whose decision prompted the hearing may request an appellate review by the Governing Body. The written request for appeal shall include a description of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for an appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by the Medical Staff Bylaws or applicable law which has created substantial prejudice; (b) the Judicial Review Committee (as such term is defined in the Medical Staff Bylaws) decision was not supported by substantial evidence, based on the hearing record; or (c) the decision of the Judicial Review Committee was not supported by the findings. The Governing Body may hear the appeal directly or it may, in its sole discretion, refer the matter to a "Hearing Officer" (as such term is defined in the Medical Staff Bylaws) for such proceedings as the Governing Body may direct. The Governing Body shall cause written notice of the time, place, and date of the appellate review to be given to each side.

3.2.3 Appellate Review Timeline

Within sixty (60) days after receipt of a notice of appeal, the Governing Body shall schedule and arrange for an appellate review. The date of appellate review shall not be less than thirty (30) days, or more than sixty (60) days, from the date of receipt by the Governing Body of the request for appellate review. When a request for appellate review is from a practitioner who is under summary suspension, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed thirty (30) days from the date of receipt by the Governing Body of the request for appellate review. The time for appellate review may be extended by the Chairman of the Governing Body for good cause.

3.2.4 Appellate Review Procedure

The appellate review shall be based upon the record of the original hearing before the Judicial Review Committee. Additional oral or written evidence may be accepted, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. In the alternative, the

Governing Body or Hearing Officer 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 present a written statement in support of their position on appeal. The Hearing Officer or Governing Body, at his/her/its sole discretion, may allow each party or representative to personally appear and make oral argument. 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. The appellate review, including any hearing that takes place as part of the appellate review, shall be conducted by designees of the Governing Body within the confines of a duly convened executive meeting of the Medical Staff in order to preserve the full scope of protections against discovery pertaining to such proceedings as provided by applicable law.

3.2.5 Action by a Hearing Officer

If the Governing Body has appointed a Hearing Officer, he/she shall prepare findings of fact and a proposed decision in such form that it may be adopted as the decision of the Governing Body. The findings of fact and the proposed decision shall be filed by the Hearing Officer with the Governing Body within fifteen (15) days after conclusion of the appellate review, and a copy thereof shall be served at the same time on the parties.

3.2.6 Final Decision

Within thirty (30) days after the conclusion of any review proceedings, the Governing Body shall render a final decision in writing. If the Governing Body determines that the practitioner was not afforded a fair hearing, the Governing Body shall remand the matter for further review. The decision made or adopted by the Governing Body shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. The final decision of the Governing Body following the appeal procedure shall be effective immediately and shall not be subject to further administrative review.

3.2.7 Notice of Decision

The Governing Body shall direct the delivery of copies thereof to the practitioner and to the Medical Executive Committee in person or by Certified or Registered Mail, Return Receipt Requested. The decision shall include notice to the practitioner that any request for judicial review under California Code of Civil Procedure Section 1094.5 must be filed within ninety (90) days following the date upon which the decision becomes final.

ARTICLE IV
DIRECTOR OF THE MEDICAL CENTER

4.1 Appointment

The Governing Body shall appoint a Director to manage the Medical Center on behalf of the Governing Body. This individual shall be the Principal Officer who has legal authority and responsibility to act for and on behalf of the organization and is responsible to the Governing Body for the day-to-day operations of the Medical Center. The State Department of Public Health shall be notified in writing whenever there is a change in the Director. The position description, with defined management objectives, serves as the basic evaluation criteria for the Director of the Medical Center.

4.2 General Duties

The general duties of the Director of the Medical Center include, but are not limited to, the following:

1. Follow and further the mission statement of the Medical Center as adopted by the Governing Body.

2. Manage the operations of the Medical Center; direct the planning, administration, and coordination of the functions and programs of the Medical Center; develop policies and procedures; prepare and maintain a strategic plan.

3. Ensure hospital policies, procedures, systems and programs comply with the requirements of all regulatory, licensing, and accrediting agencies.

4. Prepare and present the Medical Center budget to the Governing Body; direct the implementation of the budget; ensure the budget and financial activities are monitored; direct the review of all contractual agreements for services provided to or by the Medical Center.

5. Ensure compliance with all laws, statutes, rules, and regulations of Federal, State, and regulatory bodies as applicable; ensure compliance with applicable County ordinances, regulations, and policies in effect. Manage, through subordinate administrators, a large and diverse staff; confer with staff on services and operational problems to determine the needs and program effectiveness; institute changes as necessary.

6. Direct the analysis and interpretation of state and federal legislation and guidelines, and the implementation of new laws, regulations, or guidelines.

7. Participate in the activities of hospital and professional organizations.

8. Serve as a member of the Joint Conference Committee as discussed in Article IX and as a member of the Executive Cabinet, representing the Health Care Services

Group; make presentations to the Governing Body, other governmental, regulatory entities, and community organizations.

9. Perform related duties as assigned or requested.

ARTICLE V
MEDICAL DIRECTOR

The Medical Director, also known as the Chief Medical Officer (CMO), shall be appointed by the Director the Medical Center in accordance with the standards set forth in 22 CCR § 70205. This individual shall be a physician who shall have overall responsibility for the medical service provided by the Medical Center. The Medical Director shall not serve in an administrative role at any other hospital or healthcare entity without prior written consent of the Chief Executive Officer of the Medical Center. The Medical Director will be an employee of the County of San Bernardino and will not hold a physician corporation agreement with the Medical Center.

5.1 Responsibilities

The Medical Director shall:

1. Designate a number of Department Chairman, as the Medical Director deems appropriate, to act as Associate Medical Directors to provide assistance to the Medical Director and to the Medical Center in the Medical Director's absence. No monetary consideration shall be connected to the designation of Associate Medical Director.

2. Oversee the programs of medical students, interns, and residents in accordance with standards established by various federal, state, and local accrediting agencies.

3. Represent the Medical Center in meetings of professionals and other groups.

4. Monitor the daily patient care activities and bed occupancy.

5. Represent the Medical Center and assist Risk Management in its role in investigating, defending, and settling all legal actions relative to medical care.

6. Assist Medical Center Administration in strategic planning and management of the Medical Center, including planning Medical Center medical programs and determining facilities and personnel required to carry out said programs.

7. Perform other duties as assigned by the Director of the Medical Center or Governing Body.

ARTICLE VI
COMPLIANCE OFFICER

The Governing Board has ultimate responsibility for the Medical Center's compliance with applicable laws, regulations, and policies which govern its operations. The Medical Center's Compliance Department is responsible for setting policies and practices designed to ensure that the Medical Center, its employees, and independent contractors, comply with applicable health care laws and regulations. The Director of the Medical Center shall appoint an individual to serve as Compliance Officer to manage and operate the Compliance Department and Compliance Program. The Compliance Officer will meet with the Board at least quarterly to provide an overview of compliance operations during that quarter. The Compliance Department and Compliance Program policies and practices will be maintained and updated in the Medical Center's Administrative Operations Manual and Compliance Manual.

It is the policy of the Governing Board that Medical Center employees, Advanced Practice Professionals (APPs), members of the Medical Staff, and independent contractors who observe instances of possible improper or illegal conduct are responsible for reporting what they observe to their supervisors or to the Compliance Officer. Reports may be made anonymously. Anyone who retaliates against an employee or independent contractor for reporting reasonably suspected possible misconduct will be disciplined, including potential dismissal.

The Compliance Officer will investigate and resolve all complaints of improper or illegal conduct or shall ensure all complaints are investigated and resolved. The Compliance Officer will report investigative findings to the Director of the Medical Center and the Joint Conference Committee, as set forth in Article IX, below. When warranted, the Compliance Officer will report investigative findings to the Governing Body.

ARTICLE VII
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)

The Governing Body shall ensure that the Medical Center has an ongoing, hospital-wide, data-driven program for quality improvement and patient safety (the "QAPI Program), which reflects the complexity of the Medical Center's organization and services. The QAPI Program shall involve all Medical Center departments and services (including those services furnished under contract or arrangement) and focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The Governing Body shall ensure that the QAPI Program is defined, implemented and maintained and that the Medical Center maintain and be able to demonstrate evidence of its QAPI Program for review by CMS. The Medical Center shall use the data collected to (a) monitor the effectiveness and safety of services and quality of care and (b) identify opportunities for improvement and changes that will lead to improvement.

7.1 Duties of the Governing Body

The Governing Body shall take actions through the Medical Center's QAPI program to:

1. Assess the services furnished directly by hospital staff and those provided under contract or by arrangement.

2. Ensure that clear expectations for safety are established.

3. Ensure that adequate resources are allocated for measuring, assessing, improving, and sustaining the Medical Center's performance and reducing risk to patients.

4. Ensure that hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety.

5. Identify quality and performance problems.

6. Implement appropriate corrective or improvement activities and ensure that all improvement actions are evaluated.

7. Ensure that the determination of the number of distinct improvement projects is conducted annually and that the number and scope of such projects is proportional to the scope and complexity of the Medical Center's services and operations.

8. Ensure that Medical Center maintains documentation of the quality improvement activities that are being conducted, the reasons for conducting the projects, and the measurable progress achieved on the projects.

The Governing Body shall specify the frequency and detail of data collection. The Governing Body shall also ensure (a) the monitoring and sustainability of any corrective or improvement activities undertaken pursuant to the QAPI program, (b) the Governing Body, senior managers of the Medical Center and the leadership of the Medical Staff communicate with one another on issues of safety and quality, and (c) the Medical Staff participates in organization-wide performance improvement activities and communicates its findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Governing Body.

7.2 QAPI Reports

The Governing Body shall receive and review QAPI summary reports prepared by Medical Center staff at least quarterly. The summary quarterly reports shall be aggregated into an Annual Evaluation by Medical Center Staff, which, along with the Medical Center's QAPI Plan, shall be submitted on an annual basis to the Governing Body for approval. The Annual Evaluation shall include written reports on the following: (a) all system or process failures; (b) the number and type of sentinel events; (c) whether the patient and families were informed of the event; (d) all actions taken to improve safety, both proactively and in response to actual occurrences; (e) the determined number of distinct improvement projects to be conducted annually; and (f) all results of the analyses related to the adequacy of staffing at the Medical Center. At least once a year, the Governing Body shall review a written report of the results of any analysis related to the adequacy of staffing and any actions taken to resolve identified problems.

7.3 Hearings on Reports

The Governing Body may order that any hearings on the reports of medical audit or quality assurance committees and deliberations regarding such matters be held in closed session. QAPI reports may be noted in detail in closed session(s) of the Joint Conference Committee, with action taken by the full Governing Body in open session.

ARTICLE VIII
PATIENT GRIEVANCES

The Medical Center is committed to actively seeking, listening, and responding to the needs, preferences, concerns, and grievances of patients and their families. Patients are encouraged to express all concerns in order to identify opportunities to enhance patient care services. At no time shall a concern or grievance be used to deny a patient current or future access to services provided by the Medical Center.

The Governing Body delegates to a Grievance Committee the responsibility of ensuring the effective operation of a patient grievance process. The membership of the Grievance Committee and the policies and practices for reviewing and resolving patient grievances shall be maintained and updated in the Medical Center's Administrative Operations Manual.

ARTICLE IX
JOINT CONFERENCE COMMITTEE

9.1 Organization

The Joint Conference Committee shall consist of two members of the Governing Body, the Director of the Medical Center, the Medical Director, the County Chief Executive Officer, three members of the Medical Staff: Medical Staff President, Medical Staff President-Elect, and Medical Staff Past President. Other County and Medical Center staff may be invited to attend meetings to provide support, information, and guidance.

9.2 Chairman of the Joint Conference Committee

A new Chairman shall be elected annually at the fiscal year third quarter meeting of the Joint Conference Committee. The position of Chairman shall rotate between a Governing Body Joint Conference Committee member, Medical Staff Joint Conference Committee member, and the Director of the Medical Center.

9.3 Purpose and Duties

The Joint Conference Committee serves as a forum for education and discussion of issues of mutual concern related to patient care, medical policies, staffing and resources, and the relationship of the Medical Center and the members of the Medical Staff. The Joint Conference Committee provides a mechanism for promoting open communications, building strong relationships, and resolving conflicts among the Governing Body, Medical

Executive Committee, and Medical Center Administration. Additionally, the Joint Conference Committee acts as an advisory committee to the Governing Body reviewing annual reports and overseeing quality of care and patient safety.

The Joint Conference Committee shall review the following reports and make recommendation to the Governing Body regarding their approval:

1. Annual Review of the Hospital Strategic Plan
2. Annual Operating Budget and Business Plan
3. Annual Review of Physician Contract Compliance and Performance
4. Annual Review of Capital Expenditures (over $5000)
5. Annual Governing Body Self – Assessment
6. Annual Facilities Review
7. Annual Human Resource Activity Report
8. Annual Safety Report (Employee & Patient)
9. Annual Review of the Quality Assessment and Performance Improvement (QAPI) Plan
10. Annual Review of the Medical Center's Medical Risk Performance
11. Annual Review of the Medical Center's Compliance Work Plan
12. Quarterly Review of Medical Center Press-Ganey (Patient Satisfaction) Scores and HCAHPS (Hospital Consumer Assessment of Hospital Provided Services) Results

9.4 Meetings

The Joint Conference Committee shall meet a minimum of four (4) times per year and shall be subject to the Ralph M. Brown Act (Government Code section 54950 et. seq.), except that Evidence Code sections 1157 and 1157.7 and Health & Safety Code sections 1461 and 1462 shall apply with regard to the need for portions of the meetings to be held in Closed Session.

9.5 Effect of Bylaws on Joint Conference Committee

These bylaws shall supersede all prior rules, policies, or resolutions adopted regarding the establishment and activities of the Joint Conference Committee.

ARTICLE X
DISPUTE MEDIATION COMMITTEE

All disputes between Medical Center Administration or the Governing Body and the Medical Staff relating to the Medical Staff's rights of self-governance as set forth in California Business and Professions Code Section 2282.5 that have not been resolved by prior informal meetings and discussions may be addressed and mediated utilizing a Dispute Mediation Committee, with the composition as set forth below. In the event either party determines that a dispute exists, the party shall give written notice to the other party, stating the nature of the dispute. Within ten (10) business days of receipt of the notice, the parties shall appoint representatives to a Dispute Mediation Committee or the noticed party shall notify the other party of its intent to decline mediation. Neither party shall initiate any legal action related to the dispute until the Dispute Mediation Committee has completed its efforts to mediate the dispute, or mediation has been

declined. A failure to appoint representatives to the mediation committee or to decline mediation within ten days of notice may be deemed a declination of mediation.

10.1 Composition

The Dispute Mediation Committee shall be comprised of three (3) members appointed by the Governing Body, and three (3) members appointed by the Medical Executive Committee. The six (6) members shall appoint an outside professional mediator as the seventh member, and the mediator shall serve as chair of the committee, but shall have no vote. The parties shall cooperate to select the mediator from a list of candidates provided by a service such as JAMS (Judicial Arbitration and Mediation Service) or the American Arbitration Association. The cost of the mediator shall be divided equally between the parties.

10.2 Duties

The Dispute Mediation Committee shall meet and confer in good faith to formulate a recommendation for mediation of the dispute. The Committee's efforts shall continue for up to sixty (60) days. After that period, the mediator shall prepare a written report of the Committee's findings and recommendations and transmit it to the parties, or the Committee may ask for additional time to consider the dispute. Both parties must agree to any extension. If the Committee is unable to reach a consensus, the mediator shall submit a written report outlining any areas of agreement and the remaining outstanding issues. The parties may adopt the Committee's recommendations, agree to some alternative resolution of the dispute, or refer the dispute back to the Committee with instructions for further mediation efforts. Unless requested by the parties to continue its deliberations, the Committee shall dissolve thirty (30) days after the mediator has issued his/her report.