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**DEPARTMENT OF HUMAN RESOURCES
DIVISION OF CHILD AND FAMILY SERVICES**

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PUBLIC NOTICE

**A MEETING OF THE
DESERT WILLOW TREATMENT CENTER GOVERNING BOARD**

DATE OF MEETING: Monday, August 22, 2005

TIME: 5:30 p.m. to 6:30 p.m.

PLACE: Desert Willow Treatment Center
6171 West Charleston Blvd. Bldg. 17 Conference Room
Las Vegas, NV 89146

MEETING AGENDA

Items marked “*” are action items which a vote by the Governing Board may be taken.

- I. Call to Order**
- II. Introductions**
- III. Review and Approval of the Governing Board By-Laws**
- IV. Review of JCAHO Accreditation Report**
- V. Review and Approval of Revision of Medical Staff By-Laws**
- VI. Membership Recommendations**
- VII. Schedule of Future Meetings**
- VIII. Selection of Agenda Items for Next Meeting**

IX. Public Comment and Discussion (Discussion)

No action may be taken on a matter raised under this item of the agenda until the matter itself has been specifically included on the agenda as an item upon which action can be taken.

***X. Adjournment**

The Advisory Board reserves the right to take items in a different order to accomplish business in the most efficient manner.

We are pleased to make reasonable accommodations for members of the public who are disabled and wish to participate. If special arrangements are necessary, please contact Dr. Yangcha Crabb, Secretary of the Board at (702) 486-8923 no later than Thursday, August 18, 2005.

This notice has been posted at the Division of Child and Family Services, 6171 W. Charleston Blvd., Bldg. #8, Las Vegas, NV 89146; Desert Willow Treatment Center, 6171 W. Charleston Blvd, Bldg. #17, Las Vegas, NV 89146; East Neighborhood Family Service Center, 3075 E. Flamingo, #108, Las Vegas, NV 89121; North Neighborhood Family Service Center, 4538 W. Craig Road, Suite 290, North Las Vegas, NV 89032; West Neighborhood Family Service Center, 6171 W. Charleston Blvd, Bldg 7, Las Vegas, NV 89146; and http://www.dcf.state.nv.us/DCFS_Agendas.htm. In addition, this notice/agenda was mailed to groups and individuals as requested.

cc: Desert Willow Treatment Center Leadership Executive Committee
Desert Willow Treatment Center Governing Board Members
Interested members of the public
Jone M. Bosworth, Administrator, DCFS

DIVISION OF CHILD AND FAMILY SERVICES
DESERT WILLOW TREATMENT CENTER



Medical Staff Bylaws

POLICY	1.07
EFFECTIVE DATE	01/01/2005
ISSUE DATE	01/01/2005
PAGES	23
REVISION DATE(S)	01/1999; 01/2002; 01/2005
APPROVED BY:	_____

CLINICAL PROGRAM MANAGER II

PREAMBLE

The Medical Staff of Desert Willow Treatment Center shall maintain professional standards for patient care, provide patient care consistent with community standards, participate in the function of the organization in the provision of mental health services, and provide a professional educational environment for the training of physicians, Non-Physician Licensed Independent Practitioners (LIPs) and professional students from many disciplines.

Article I: NAME OF ORGANIZATION

The name of this organization shall be the Medical Staff of Desert Willow Treatment Center (DWTC). DWTC is a program of the Department of Human Resources (DHR), Division of Child and Family Services (DCFS).

Article II: RELATIONSHIP BETWEEN THE MEDICAL STAFF AND THE LEADERSHIP EXECUTIVE TEAM

Section 1: Bylaws, Rules, and Regulations

- A. The members of the DWTC Medical Staff, through the Bylaws and Executive Team, may revise the Bylaws and make these recommendations to the Leadership Executive Team. Only after approval, by the Leadership Executive Team, shall these revisions become effective. Neither the Medical Staff nor the Leadership Executive Team may unilaterally amend the Medical Staff Bylaws.
- B. The local Governing Board has the final authority over the operation of the facility, Medical Staff appointment, and privileging for all practitioners. The local Governing Board charges the Medical Staff with the care of patients in the facility.
- C. The Credentialing and Privileging Committee, in accordance with all applicable NRS, NAC, and standards of Joint Commission on Accreditation of Healthcare Organizations (JCAHO), makes recommendations to the Leadership Executive Team regarding:
 - 1. Structure of the Medical Staff

Section No:	<u>1.07</u>
Subject:	<u>Medical Staff Bylaws</u>
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2. Mechanisms for reviewing applications for Medical Staff membership and privileging.
 3. Individual Medical Staff memberships and privileges.
 4. Mechanisms for termination of Medical Staff membership.
 5. Mechanisms for the fair hearing procedures regarding Medical Staff membership, privileging, discipline, or Medical Staff termination.
- D. The Leadership Executive Team acts upon these recommendations and approves the mechanisms by which the Medical Staff can fulfill its obligations with final approval of the DWTC Governing Board.
- E. The DWTC Governing Board grants final approval of changes to the Medical Staff Bylaws.

Article III: RELATIONSHIP BETWEEN THE MEDICAL STAFF, DESERT WILLOW TREATMENT CENTER, AND THE UNIVERSITY OF NEVADA.

Section I: Nothing in the Medical Staff Bylaws is intended to govern employment contractual relationship between members of the Medical Staff, Desert Willow Treatment Center, and the University of Nevada.

- A. Employment contractual relationships for classified physicians are governed by state personnel policy.
- B. Employment contractual relationships for non-classified physicians are governed by the Inter-local or Contractual Agreement between Division of Child and Family Services and the University of Nevada or other outside entity.

Article IV: MEMBERSHIP OF THE MEDICAL STAFF

Section 1: Nature of Membership

Membership in the Medical Staff shall be extended to licensed psychiatrists, non-psychiatric physicians, and LIPs. The Credentials and Privileging Committee shall review the Medical Staff credentials, and forward them with recommendations through the DWTC Medical Director to the Leadership Executive Team for approval, with subsequent and final approval by the Governing Board.

Section 2: National Practitioner Data Bank

Members of DWTC Medical Staff are subject to the provisions of the Health Care Quality Improvement Act of 1986 that mandate reporting of specific actions or events to the National Practitioner’s Data Bank (i.e. an adverse professional action that exceeds three months, revisions of professional review actions, and the voluntary surrendering of Medical Staff membership or clinical privileges.

Section 3: Qualification for Membership in Medical Staff

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- A. Physicians and LIPs who document the following shall be qualified for membership on the Medical Staff:
1. Training, experience and health status to perform required duties and proficiency in the English language;
 2. Adherence to standards of professional ethics, and continuing competence to perform required duties;
 3. Professional reputation and standing in the community;
 4. Recommendation from three (3) peers;
 5. Current licensure in Medicine or Osteopathy by the Nevada State Board of Medical or Osteopathic Examiners or, in the case of LIPs, licensure by the appropriate State licensing board;
 6. Current Drug Enforcement Agency and Nevada Board of Pharmacy Controlled Substances Certification if required;
 7. For Psychiatrists, completion of a four (4) year ACGME accredited residency in psychiatry. Psychiatrists shall become Certified by the American Board of Psychiatry and Neurology (ABPN) within five (5) years of their date of employment with the organization, as per NRS 433.267.
- B. No applicant shall be denied membership on the basis of age, sex, religion, creed, color, national origin, or physical disability.

Article V: CATEGORIES OF THE MEDICAL STAFF

Section 1: Membership Categories

- A. **ACTIVE:** The Active staff shall consist of physicians who are at least half time permanent employees of the State of Nevada, and/or physicians/LIPs employed on contract at least twenty (20) hours per week to provide medical services at the facility. They shall be eligible to vote and to serve on Medical Staff Committees. All Active staff shall have completed at least one (1) year as an Associate staff member.
- B. **PROVISIONAL/ASSOCIATE:** The Provisional/Associate staff shall consist of all physicians/LIPs during the first year of appointment to the Medical Staff. Provisional/Associate staff members shall be eligible to vote and serve on Medical Staff Committees.
- C. **COURTESY:** Physicians/LIPs who are not active members of the Medical Staff and whose advice, counsel, court ordered involvement in accordance with NRS, or assistance if desirable, may be designated as Courtesy staff members, on the recommendation of the Medical Director. Their duties shall be limited to those specifically designated by the DWTC Medical Director. They shall not be entitled to vote, but can attend and participate in Medical Staff meetings and Committees. Medical and psychiatric residents under the supervision of active and associate Medical Staff shall be included in this category.

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Article VI: PROCEDURES FOR APPOINTMENT TO THE MEDICAL STAFF

Section 1: Application for Membership to the Medical Staff

Application forms for membership to the Medical Staff shall be available from the Credentials and Privileging Committee.

- A. All applicants for membership to the Medical Staff shall be in writing specifying the privileges requested, and shall be signed by the applicant. The application shall require detailed information concerning the applicant's professional qualifications and experience, and shall include the names of at least three (3) persons who have had extensive experience working with the applicant, who can provide information pertaining to the applicant's current competence, ethical character and physical and mental health. The applicant shall furnish information concerning membership in local, state, and national professional societies. The applicant shall include information concerning privileges ever being revoked, suspended, reduced, or not renewed at any other hospital or institution; being involuntarily terminated; or state licensure to practice in any jurisdiction ever being suspended or terminated. Applications shall include information regarding any involvement in negligence actions, malpractice lawsuits and outcomes.
- B. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her character, competence, and other qualifications to the satisfaction of the Credentials and Privileging Committee.
- C. In applying for Medical Staff appointment, the applicant signifies his/her willingness to appear for interviews regarding his/her application, authorizes the representatives of the Credentials and Privileging Committee, the Agency, and the State of Nevada to consult with members of the professional staff of other hospitals and agencies with whom the applicant has been associated, authorizes representatives to consult with others who may have qualifications, authorizes inspection by the above of all records and documents that may be material to the evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests as well as his/her moral and ethical qualifications for membership. By applying for appointment to the Medical Staff each applicant specifically agrees that State of Nevada personnel records shall be available to the Medical Director and to the members of the Credentials and Privileging Committee. In addition, by applying, the applicant releases from any liability the Credentials and Privileging Committee, DWTC, The State of Nevada, and their respective officers, employees or agents for their acts performed in good faith and without malice in connection with the evaluation of the applicant and his/her credentials, and also releases from any liability all individuals and organizations who provide information to applicant's character, competence and ethical qualifications for credentialing and privileging including otherwise privileged or confidential information.
- D. The application form shall include a statement that the applicant has received and read the Medical Staff Bylaws of DWTC and any rules and regulations which may apply, and that he/she agrees to be bound by the terms without regard to whether he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application. The applicant will sign this form prior to background checks being initiated.

Section 2: Appointment Process for Initial Application

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- A. The applicant shall submit the completed application for membership to the Credentials and Privileging Committee, which shall verify the references, education, training, licensure, and other qualifying evidence submitted. The National Practitioner Data Bank shall be queried for all new applicants to the Medical Staff or for clinical privileges at DWTC. The Credentials and Privileging Committee shall notify the Medical Director of all findings. The Medical Director shall promptly notify the applicant of any problems in obtaining the required information. When collection and verification is accomplished, the Medical Director shall forward the application and all supporting materials to the Credentials and Privileging Committee for action.
- B. Within thirty (30) days after receipt of a verified membership application, the Credentials and Privileging Committee shall review the information submitted and forward its recommendation to the Leadership Executive Team through the Medical Director. These recommendations shall include specific clinical privileges. The Leadership Executive Team will brief the Governing Board on their recommendations.
- C. When the recommendation of the Leadership Executive Team is to defer the application for further consideration, it shall be followed up within sixty (60) days with a subsequent recommendation for appointment to a designated membership category with specific privileges or to deny the appointment.
- D. When the recommendation of the Leadership Executive Team is favorable to the applicant, this recommendation shall be forwarded to the Medical Director for referral to the Governing Board. Within fourteen (14) days after the receipt of a favorable recommendation by the Leadership Executive Team, the Medical Director shall act on the matter.
- E. When the recommendation of the Leadership Executive Team is adverse to the applicant, either in regard to appointment or clinical privileges, the Medical Director shall promptly notify the applicant by certified mail with return receipt requested. The applicant may contact the Medical Director for a Peer Review of the application within fourteen (14) days of receipt of the adverse recommendation. The Medical Director shall then appoint a Peer Review Committee to review the application and all submitted materials, and to make a recommendation within fourteen (14) days. The Medical Director shall provide a Peer Review Committee report to the Governing Board who shall render a decision within fourteen (14) days. The applicant can then appeal the Governing Board's adverse decision to the Attorney General. The decision of the Attorney General is final.
- F. Upon approval of the initial appointment by the Governing Board, the first term shall be limited to twenty-four (24) months.
- G. For qualified applicants who have received a positive recommendation from the Leadership Executive Team, the decision on initial applications, reappointment applications and renewal or modification of clinical privileges may be made by an expedited meeting of the Governing Board, consisting of at least two (2) members of the Governing Board who will review and approve the credentialing recommendations. A positive decision by the expedited meeting of the Governing Board shall result in the status or privileges requested.

Section 3: Reappointment Process

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- A. Reappointment to the Medical Staff shall require a written commendation by the Medical Director which shall be based upon a review and evaluation of the following:
1. Current competence based on professional performance, judgment, and clinical skills; the current annual evaluation which is based on the work performance standards judged by the supervisor who is an active or associate member of the Medical Staff and appointment by the Medical Director.
 2. Regular attendance of the scheduled Medical Staff meetings including performance on the assigned Medical Staff and DWTC Committees is expected.
 3. Evidence of continuing education necessary for professional licensure.
 4. Health status: The candidate for reappointment shall be required to submit any reasonable evidence of current health status that may be requested by the Governing Board.
 5. Compliance with Quality Improvement, Medical Staff, Desert Willow Treatment Center and Division of Mental Health standards.
 6. Medical Staff chart and Peer Review (which is an ongoing review of physician's/LIP's treatment planning and clinical practice).
 7. Continued professional licensure in Nevada and maintenance of a current Drug Enforcement Agency and Nevada Board of Pharmacy Controlled Substances certificate if required.
 8. Results of querying the National Practitioners Data Bank which shall occur every two (2) years for reappointment and reprivileging.
- B. A reappointment and reprivileging form shall be mailed to each physician/LIP at least ninety (90) days prior to the end of the physicians period of appointment (every two (2) years) by the Credentials and Privileging Committee. Within fifteen (15) days after receipt, the applicant shall complete such forms and submit the same to the Credentials and Privileging Committee.

Such forms shall require information concerning changes in health status and qualifications of the applicant since the previous review of the applicant's qualifications, including, but not necessarily limited to, privileges requested, evidence for change of privileges, continuing education, present status of licensure, and certification.

- C. The Credentials and Privileging Committee shall review the verified application, the applicant's competence and clinical judgment in the treatment of patients, his/her ethics and conduct; maintenance of timely, accurate and complete medical records; attendance at required meetings; compliance with the Medical Staff Bylaws, rules and regulations; cooperation with Agency personnel; relations with other professionals; his/her general attitude toward patients, the organization and the public. Information concerning these criteria shall be requested from the appropriate resources as required and forward recommendations to the Leadership Executive Team.

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- D. At the first regularly scheduled meeting following receipt of the recommendation of the Credentials and Privileging Committee, the Leadership Executive Team shall submit a written recommendation to the Medical Director, concerning the reappointment and reprivileging of the applicant. The Medical Director shall present these recommendations at the next regularly scheduled meeting of the Governing Board for final approval. When reappointment or reprivileging is not recommended by the Credentials and Privileging Committee, the reasons shall be stated in a written report signed by the Chairperson of the Committee, including a tally of voting results. This report is to be submitted to the Medical Director.

Thereafter, the procedures provided in Article VIII: Corrective Action, Section 3: Summary Suspension, shall be followed.

Article VII: CLINICAL PRIVILEGES

Section 1: Privileges for Physicians

- A. Every physician/LIP who practices at the facility shall be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Board. Privileges shall be granted upon documented education, training, experience, continued competence, health status and judgment.
- B. Every application for privileging and reprivileging shall contain a request for specific clinical privileges desired by the applicant on the prescribed appointment and privilege forms. The evaluation of such requests shall be based upon documentation and verification of the applicants education, training, experience, demonstrated current competence, health status, judgment, references, and other relevant information. The applicant shall have the burden of establishing qualifications and competence on the requested appointment and privileges forms to the satisfaction of the Medical Director and the Credentials and Privileging Committee.
- C. Applications for additional clinical privileges shall be submitted in writing on the appointment and privileges forms. Such applications shall be processed in the same manner described above.
- D. Periodic or otherwise indicated evaluations of clinical privileges and changes of privileges shall be carried out as part of the biennial appointing and privileging process.

Section 2: Conditions and Duration of Appointment

- A. The Governing Board shall act on appointments, reappointments, or revocation from the Credentials and Privileging Committee submitted through the Medical Director as provided for in these Bylaws. In a case where there is an unwarranted delay on the part of the Credentials and Privileging Committee or in an emergency situation, the Medical Director may act without such recommendation after consultation with the Attorney General.
- B. Credentialing, privileging and reprivileging shall be for a period of not more than twenty-four (24) months.

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- C. The appointee shall practice only within the scope of the clinical privileges approved by the Governing Board.

Section 3: Temporary Privileges for Physicians/LIPs

There are three circumstances for which the granting of temporary privileges would be acceptable:

- A. To fulfill an important patient care need
- B. When an applicant with a complete, clean application is awaiting review and approval of the Leadership Executive Team and the Governing Board
- C. In accordance with NRS 433B as it relates to court ordered evaluations by a licensed psychiatrist or any licensed physician.

In the first circumstance temporary privileges can be granted on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Written prior notification and/or a signed and executed Court Order must be submitted to the Medical Director requesting temporary privileges.

Examples would include, but are not limited to:

- A. A situation where a staff member becomes ill or takes a leave of absence and a non-staff member would need to cover his/her practice until he/she returns (locum tenens)
- B. A specific physician/LIP has the necessary skills to provide care to a patient that a staff member currently privileged does not possess
- C. A proceeding for the court-ordered admission of a child alleged to be emotionally disturbed would follow the process outlined in NRS 432B where a court ordered treatment evaluation is required by a new staff member

In these circumstances, temporary privileges may be granted by the Clinical Program Manager II upon recommendation of the Medical Director provided there is verification of:

- A. Current licensure
- B. Current competence
- C. Current malpractice insurance
- D. Relevant training
- E. Executed Court Order

In the second circumstance, temporary privileges may be granted when the new applicant for medical staff membership or privileges is waiting for a review and recommendation by the medical staff and approval by the Governing Board. Temporary privileges may be granted for a limited period of time, not to exceed 120 days, by the Clinical Program Manager II upon recommendation of either the applicable clinical department chairperson or the Medical Director provided:

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- A. There is verification of:
 - 1. Current licensure
 - 2. Relevant training or experience
 - 3. Current competence
 - 4. Ability to perform the privileges requested
 - 5. Other criteria required by medical staff bylaws
- B. The results of the National Practitioner Data Bank query have been obtained and evaluated
- C. The applicant has:
 - 1. A complete application
 - 2. No current or previously successful challenge to licensure or registration
 - 3. Not been subject to involuntary termination of medical staff membership at another organization
 - 4. Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges
- D. Disaster privileges may be granted when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs. Disaster privileges may be granted upon presentation of a current license to practice and a valid picture ID issued by a state, federal, or regulatory agency and/or identification indicating that the individual is a member of Disaster Medical Assistance Team (DMAT).

In the 3rd circumstance, Court Ordered Practitioners will be granted temporary privileges limited to medical and psychiatric evaluations and treatment consults exclusively with verification of:

- A. Current licensure
- B. Current competence
- C. Current malpractice insurance
- D. Relevant training
- E. Executed Court Order

Temporary privileges are not to be routinely used for other administrative purpose such as the following situations:

- A. The staff member fails to provide all information necessary to the processing of his/her reappointment in a timely manner
- B. Failure of the staff to verify performance data and information in a timely manner

In the above situations, the practitioner would be required to cease providing care in the facility until the reappointment process is completed.

If, in the above reappointment situations, the failure to allow the practitioner to continue to provide care would result in a problem meeting an important patient care need, then temporary privileges could be granted.

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Article VIII: CORRECTIVE ACTION

Section 1: Disciplinary Procedures Relating to Clinical Privileges

The following procedures shall be followed when any act, omission or occurrence of any practitioner with clinical privileges is considered to be cause for corrective action.

- A. Any member of the Medical Staff, any licensed organization professional, manager of any organization, department or program, Chairperson of any standing organization Committee, the DWTC organization, or the DWTC Medical Director may request corrective action against any practitioner. All requests for corrective action shall be submitted in writing to the Division of Child and Family Services Personnel office. These requests shall be supported by reference to the specific conduct or activities which constitute grounds for the request and shall be submitted by the Medical Director to the Chairperson of the Credentials and Privileging Committee who shall notify the practitioner’s supervisor. The Credentials and Privileging Committee shall address the complaint at a scheduled meeting, and shall forward a report to the Division of Child and Family Services Personnel office within fifteen (15) working days of receipt of the complaint.
- B. Within ten (10) working days of receipt of the Credentials and Privileging Committee report, the Medical Director shall deliver to the practitioner a notice of action and the effective date of the action. The corrective action may include, but shall not be limited to: reduction, suspension, revocation of clinical privileges, to recommend an already imposed summary suspension of clinical privileges to be terminated, modified or sustained, or appointment revoked. If the Credentials and Privileging Committee finds no substantiation for the complaint, a report shall be submitted to the Medical Director indicating such. The Medical Director shall inform the practitioner of the Credentials and Privileging Committee report.

If the Medical Director questions the decision of the Credentials and Privileging Committee, the Attorney General will be consulted to review the findings and recommendations of the Committee and return his/her recommendations to the Committee for further consideration.

- C. (A) Practitioner may follow the grievance procedure outlined below for any adjustment of corrective action relating to clinical privileges. The procedure is as follows:
 - 1. Within ten (10) working days, a dissatisfied practitioner may appeal the Medical Director’s decision by requesting an ad-hoc Professional Staff Review consisting of at least two (2) privileged physicians appointed by the Medical Director. The Professional Staff Review Committee has ten (10) working days to review the action taken, and make recommendations to the Medical Director or designee.
 - 2. The Medical Director has ten (10) working days to inform the practitioner of the final decision based on the Profession Staff Review Committee’s recommendation.

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Section 2: Disciplinary Procedures Not Relating to Clinical Privileges

It is not the intent of the Medical Staff Bylaws to govern disciplinary procedures unrelated to clinical privileges. (Whenever the activities of any practitioner employed by the State are in direct violation of NAC 284.650 or Division of Child and Family Services Prohibitions and Penalties, the disciplinary procedure as outlined in the NAC 284.638 through NAC 284.656 shall be followed. The disciplinary action, as outlined above, may be appealed through policy and procedures as contained in NRS 284.390. A copy of the final decision of disciplinary action and results of appeals shall be sent to the Chairperson of the Credentials and Privileging Committee.)

- A. Disciplinary procedures unrelated to clinical privileges for practitioners employed at the organization as classified physicians are defined by NAC 284.650 or the Department of Human Resources Prohibitions and Penalties. In this instance, the disciplinary procedure outlined in the NAC 284.638 through NAC 284.656, shall be followed.
- B. Disciplinary procedures unrelated to clinical privileges for practitioners employed at the organization as unclassified University physicians are defined and covered by the Inter-local Agreement between the Division of Child and Family Services and the University of Nevada or other contractual entity.

Section 3: Summary Suspension

- A. The DWTC Medical Director has the authority to take action immediately after consultation with the Attorney General in the best interest of patient care of the organization and to suspend all or any portion of the clinical privileges of a practitioner, and such suspension shall become effective upon service of written notice to the practitioner. Grounds for summary suspension shall include, but are not limited to, action by a state licensing authority revoking or suspending a practitioners state license or controlled substances certificate; or engaging in any prohibited conduct enumerated in NAC 630.230.
- B. Upon the imposition of a summary suspension, the Medical Director shall provide for alternative medical coverage for the patients of the suspended practitioner still (in) under the care of the facility at the time of such suspension.
- C. For classified State of Nevada Employees the summary suspension may be appealed through policy and procedures as contained in NRS 284.390, (for classified State of Nevada Employees only).

Article IX: OFFICERS

Section 1: DWTC Medical Director

Shall be appointed by the DWTC Clinical Program Manager II. The credentials of the Medical Director are subject to the review and approval of the DWTC Governing Board.

Section 2: Qualifications

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The Governing Board shall include members of the Active Medical Staff.

Section 3: Duties

A. DWTC Medical Director

1. The DWTC Medical Director serves on the Governing Board, with full voting privileges.
2. The DWTC Medical Director is responsible for insuring that the organization Medical Staff Bylaws are current and in compliance with applicable statutes, regulations and standards.
3. The Medical Director has the authority to veto appointments to the Medical Staff, to fill staff vacancies with appointments, to recommend non-renewal of physician employment contracts, and to assign duties and responsibilities to the Medical Staff, in addition to all duties imposed by law.
4. The Medical Director has the authority to contract on behalf of the Medical Staff for medical services not available at the organization by reviewing and approving consultant qualifications, licensure and accreditation documentation.
5. The Medical Director reports to the DWTC Clinical Program Manager II and represents the organization at professional, civic, governmental, regulatory and fiscal meetings that are pertinent to the clinical operations of the organization.

B. Chief of Staff

1. The Medical Director acts as the Chief of the Medical Staff.
2. The Medical Director, as Chief of Staff presides at all Medical Staff meetings.
3. The Medical Director, as Chief of Staff is responsible for enforcement of the Medical Staff Bylaws, rules and regulations.
4. The Medical Director keeps all Medical Staff members informed of current organization programs, policies and procedures, and represents the views, policies and needs of the Medical Staff to the DWTC Clinical Program Manager II.
5. The Medical Director is responsible for conducting Medical Staff quality improvement activities with the cooperation of the Quality Assurance Specialist, Director of Medical Records, Director of Nursing, and other appointed personnel.
6. The Medical Director convenes Medical Staff meetings as deemed necessary.
7. The Medical Director shall review the credentials files of all physicians applying for reappointment, evaluate the applicants based upon criteria specified in the Medical Staff Bylaws, and prepare written recommendations to the Leadership Executive Team for review.

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Article X: COMMITTEES

Section 1: Governing Board

- A. Composition: The membership of the Governing Board shall consist of the DWTC Medical Director, Director of Nursing, Quality Assurance Specialist and the DWTC Clinical Program Manager II. The DWTC Clinical Program Manager II shall serve as the Secretary of the Governing Board.
- B. Frequency of Meeting: The Governing Board shall meet at least quarterly.
- C. Attendance Requirement: The Governing Board members shall attend at least seventy-five (75) percent of all Governing Board meetings unless attendance is excused.
- D. Duties of the Governing Board shall include:
 - 1. Oversight of the activities and general policies for the provisions of patient care.
 - 2. To act upon the recommendations of the Credentials and Privileging Committee concerning all physician applications.
 - 3. Review for the Quality Improvement and organizational performance improvement activities of the organization and assure that peer review is conducted with follow-up actions as needed.
 - 4. To receive reports and recommendations from other organizations' Committees and recommend action necessary to the Medical Director.
 - 5. Make recommendations regarding the Medical Staff structure; mechanism used to review credentials and to delineate individual clinical privileges; recommendations for delineated clinical privileges for each eligible individual; participation of the Medical Staff in organizational performance with the mechanism used to conduct, evaluate, and revise performance improvement activities; mechanism by which Medical Staff membership may be terminated; mechanism for fair hearing procedures; make recommendations directly to the Leadership Executive Team for approval.
 - 6. Take all reasonable steps to assure ethical conduct and competent clinical performance by all members of the professional staff. Initiate and/or participate in corrective or review measures when warranted.

Section 2: Credentials and Privileging Committee

- A. Composition: The Medical Staff Credentials and Privileging Committee shall consist of the Medical Director, who shall serve as the Chairperson, and the Quality Assurance Specialist, Director of Nursing, the Leadership Executive Team, and the DWTC Clinical Program Manager II.

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B. Frequency of Meetings: The Credentials and Privileging Committee shall meet at least biannually, or more frequently as needed.

C. Duties:

1. Review and evaluate application for membership and privileging for the Medical Staff using the criteria stipulated in these Bylaws.
2. Review the results of quality improvement reports and personnel records to evaluate reappointment applications.
3. Make recommendations to the Medical Director and the Medical Staff regarding appointments and privileges within thirty (30) days of receiving an application.
4. Make recommendations to the Medical Director and the Medical Staff regarding reappointments and reprivileging sixty (60) days before the expiration of appointment.

D. Organizational Sequence: The Credentials and Privileging Committee reports directly to the Leadership Executive Team regarding a physician's credentials and privileging.

Section 3: Medical Services Committee

A. Composition: The membership of the Medical Services Committee (MSC) shall consist of the Medical Director, the Director of Nursing, the Quality Assurance Specialist, at least one (1) additional psychiatrist, a clinical Psychologist, and others appointed by the MSC. The Medical director will serve as the Chairperson.

B. Frequency of Meeting: The Committee shall meet as deemed necessary to conduct business, but not less than one (1) meeting annually. The Committee shall maintain a permanent record of its proceedings.

C. Duties: The Committee shall be responsible for the development and surveillance of all medication usage policies and practices within the facility in order to assure optimum clinical results and a minimum potential for hazards. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, manufacture, distribution, use, safety procedures, and all other matters related to medications in DWTC. The Committee shall also perform the following specific functions:

1. Serve as an Governing group to the Medical Staff on matters pertaining to the choices and cost of available medications;
2. Encourage a high standard of medication therapy and rational medication prescribing at the facility;
3. Provide physicians with quality products and an adequate selection of medication to enable the prescribing physicians to provide high quality medication therapy while coordinating the ordering and purchasing of medication to effect cost savings;

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4. Develop, maintain and periodically review the Medication Formulary for the facility. Prevent unnecessary duplication in the stocking of medications and the utilization of medications in combination having identical amounts of the same therapeutic ingredients;
5. Utilize the medication information resources of the organization for educational purposes to improve the quality of medication therapy;
6. To periodically review high use and high cost medication items and make appropriate recommendations;
7. Monitor medication errors, all adverse medication reaction events, and report trends to the Medical Staff;
8. Conduct medication usage studies and report findings to the Medical Staff.
9. Develop and maintain safe and effective infection control practices, policies and procedures.
10. Monitor infection control trends, antibiotic usage and nosocomial rates.
11. Evaluate dietary practices including special diets, food and drug interactions and nutritional assessment and education.

D. Organizational Sequence: The Medical Services Committee reports as necessary to the Leadership Executive Team.

Section 4: Leadership Executive Team Committee

- A. Composition: The Leadership Executive Team (LET) shall consist of the Clinical Program Manager II, the Medical Director, Quality Assurance Specialist, Director of Nursing, a Clinical Psychologist, Facility Manager, Clinical Program Manager I, and others appointed by the LET. The DWTC Clinical Program Manager II shall chair the committee.
- B. Frequency of Meeting: The Committee shall be scheduled to meet at least monthly to conduct business, but shall convene not less than ten (10) meetings annually.
- C. Duties:
 1. Review the Medical Staff Bylaws for currency, adequacy, and compliance with applicable regulations and standards;
 2. Report findings/recommendations to the Governing Board;
 3. Explain the basis for any proposed revisions to the Medical Staff during a regular Medical Staff meeting.

D. Organizational Sequence to modify the Bylaws:

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1. The LET Committee shall recommend to the Medical Staff proposed changes in the Bylaws.
2. Revisions to the Medical Staff Bylaws require a formal vote of adoption by a majority of the Active and Associate members of the Medical Staff.
3. Modifications that require legal review shall be submitted to the Deputy Attorney General for review and response.
4. The Leadership Executive Team shall approve the changes by a majority vote before they are forwarded to the Governing Board.
5. The Governing Board shall review and approve/disapprove the changes adopted by the Leadership Executive Team Committee.

Article XI: COMMITTEE MEETINGS

Section 1: Frequency

Unless specified elsewhere in these Bylaws, each Committee shall meet at least quarterly. Any Committee may meet more frequently to conduct necessary business.

Section 2: Notice of Meetings

Notice of meetings shall not be required for Committees that meet at regular and predictable times, for those Committee meetings with full attendance, or for those Committee meetings for which absent members have waived notice. Governing Board meetings shall be posted for public notice “not later than 9:00am of the third working day before the meeting” in accordance with all applicable NRS and NAC.

Section 3: Quorum

The number of members present, but not less than three (3) at any Committee meeting shall constitute a quorum for the conduct of normal or routine business. Important issues or special matters shall require at least fifty (50) percent of the Committee membership to be present before a decision can be final. Under certain conditions (i.e. staff shortages) the Clinical Program Manager II may suspend Committee functions and rely on the Chairperson for Committee activities.

Section 4: Manner of Action

When a Committee cannot reach a consensus, the majority rules.

Section 5: Rights of Ex-officio Members

Physicians and non-physician clinicians serving under these Bylaws as ex-officio members of a Committee shall have all the rights and privileges of regular Committee members, except voting privileges.

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Section 6: Minutes

The Committee Chairperson shall appoint a recorder to prepare minutes of all Committee meetings according to a standard format prepared by the Clinical Program Manager II. Copies of Committee minutes shall be sent to all members of the Committee and to members of the Leadership Executive Team. Each Committee shall maintain a permanent file of the minutes of every meeting. When relevant, minutes from a Committee shall be sent to non-members for purposes of communication.

Section 7: Alternates

Alternate Committee members may be designated by all Committee members. A Committee member shall not be considered absent when a meeting is attended by an alternate.

Section 8: Attendance Requirements

Committee members and not their alternates shall personally attend at least seventy-five (75) percent of all meetings of each Committee on which they serve as members unless attendance is excused.

NOTE: “Rules, Regulations, Policies and Procedures” have been deleted from the Medical Staff Bylaws and stand as a separate document.

Article XII: AUTHORITY OF THE DWTC MEDICAL DIRECTOR

Section 1: Appointments, Terminations etc.

Appointments and reappointments to the Medical Staff, granting clinical privileges, suspensions, and terminations including denial of reappointment to the Medical Staff of staff privileges of any person shall be effective when approved by the DWTC Medical Director and approved by the Clinical Program Manager II, with the exception of Section 2 of this article.

Section 2: Granting and Withdrawing of Privileges

Notwithstanding any other provisions of these Bylaws, the DWTC Medical Director with approval of the DWTC Clinical Program Manager II, in the interest of patient care and in his/her discretion, in consultation with the Attorney General has the authority to temporarily grant clinical privileges other than those requested, as well as modify, suspend, or terminate the appointment and/or all or part of the clinical privileges of any person pending full approval by the Governing Board and the Leadership Executive Team.

Section 3: Responsibility of the DWTC Medical Director

Notwithstanding any other provisions of these Bylaws, the DWTC Medical Director has final authority and responsibility for the medical care provider by the facility.

Article XIII: CONFLICTS

In the event of a conflict between the provisions of these Bylaws and the contract(s) under which a physician is employed, the contract(s) shall take precedence. In the event of a conflict between the

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provisions of these Bylaws with the Nevada Revised Statutes, the provisions of the latter shall take precedence.

Article XIV: AMENDMENTS

Amendments to the Medical Staff Bylaws are made in accordance with the procedure specified under the Leadership Executive Team Committee, Article X, Section 4. This set of Medical Staff Bylaws represent a comprehensive revision to the existing Medical Staff Bylaws which were adopted and approved by the Leadership Executive Team on January 2002.

Recommended by the Leadership Executive Team on January 6, 2005

Chairperson of the Leadership Executive Committee Date

Adopted by the Governing Body on April 25, 2005

Chairperson of the Governing Board Date

Article XV: RULES, REGULATIONS, POLICIES AND PROCEDURES

Section 1: Psychiatric Supervision

- A. All inpatients receiving care from the facility shall have an assigned, attending psychiatrist who is an active, associate or courtesy member of the Medical Staff. This physician is ultimately responsible for all aspects of care including medical therapies. The delegation of any and various aspects of this treatment shall not be constructed as an abrogation of this responsibility of authority. The psychiatrist shall lead an interdisciplinary team to develop treatment plans for assigned patients.
- B. Medical students and residents shall be under the direct supervision of the attending psychiatrist during their rotations at the facility.
- C. All decisions regarding inpatient admissions shall be the responsibility of the attending psychiatrist, the on call psychiatrist, the Medical Director or a physician designated by the Medical Director.
- D. All decisions regarding inpatient discharges shall be the responsibility of the attending psychiatrist, or in his/her absence, the on call psychiatrist, Medical Director or a physician designated by the Medical Director.
- E. While the DWTC Medical Staff supports the educational endeavors of professional students in varying disciplines, at all times:
 - 1. Professional students shall be directly supervised by a licensed practitioner of the students' discipline;
 - 2. Patients shall consent in writing to student participation in their care on the general consent form;

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3. Students may never act in place of a clinically privileged professional;
 4. Medical Staff, non-physician clinicians and patients shall not be subject to denial of limitation of privileges for choosing not to participate in student training programs.
- F. DWTC physicians shall not supervise practitioners at other facilities when patients are transferred for services not provided by the organization (i.e. alcohol and drug detoxification, blood transfusions, acute medical or surgical therapies, electro convulsive therapy).

Section 2: Operating Rules and Regulations

- A. DWTC shall admit patients per the admission criteria.
- B. Patients shall be treated by physicians who have been duly appointed to membership on the Medical Staff, and granted clinical privileges by the Medical Director.
- C. Medical staff members shall be assigned to Officer of the Day call as determined by the Medical Director or his/her designee. There will be a designated physician on-call 24-hours per day. It is the responsibility of the on-call physician to evaluate and treat all patients admitted to the facility, and any patients that have been in seclusion or restraint. While on call, the physician shall be available by pager or telephone within fifteen (15) minutes of being called. It is the responsibility of the on-call physician to arrange for back up coverage should he/she be unable to perform the required duties during the assigned shift.
- D. Patients shall only be admitted on the order of the attending or on-call psychiatrist. An order shall be given by telephone if the physician is off of the DWTC campus, or written by the physician when he/she is on campus. For the admission orders, the physician shall specify an admitting diagnosis, dietary requirements, frequency of vital signs, level of precautions, and initial plan of care involving medication, laboratory studies, and consultations. Telephone orders shall only be accepted by registered nurses, and must be signed by a physician within twenty-four (24) hours.
- E. Medical Staff physicians shall report for duty at 0800 Monday through Friday, and are expected to remain on campus until 1700, except during the lunch hour. While the routine day shall involve eight (8) hours of activities, additional work may be assigned by the Medical Director to respond to clinical requirements. There is no additional compensation for these extraordinary duties. Flexible schedules shall be negotiated with the Medical Director, and may only be granted when the facility coverage requirements are satisfied.
- F. Within twenty-four (24) hours of an acute admission and five (5) days of a residential admission, each patient shall have a medical evaluation and physical examination performed unless a comprehensive examination has been performed within the prior seven (7) days and the written report is included in the DWTC medical record. The physician shall report the presenting problem, personal and family medical history, social history, review of systems, and a physical examination, which includes a thorough neurological assessment mentioning mental status, cranial nerves, muscle strength and tone, sensation, deep tendon reflexes, coordination, and presence or absence of tics, tremors or tardive dyskinesia.

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- ~~G.~~ Within twenty-four (24) hours of an acute admission and five (5) days of a residential admission, a comprehensive psychiatric evaluation must be completed as per DWTC policy.
- H. Progress notes are required daily for patients on the acute units to document the need for ongoing acute care. Progress notes shall be written at least weekly for patients on the Residential Treatment Units by the attending psychiatrist, but shall be written more frequently when necessary to justify the clinical rationale for therapies selected, changes in medication or dosage, changes in clinical status, whenever an adverse reaction or untoward event occurs. Progress notes will address the active problems cited in the Treatment Plan. As new problems are identified or older problems are resolved, the progress notes shall reflect these changes.
- I. Appropriate laboratory and medical tests will be ordered by the physician as per DWTC Policy.
- J. The interdisciplinary team approach shall be utilized for every patient's care. The Master Treatment Plan shall be completed by the fifth (5th) working day, and developed by all members of the treatment team. The team shall present the plan for signature to the patient and parent/legal custodian. The treatment team shall review the treatment plan at least weekly. The Master Treatment Plan shall include the individual identified problems with goals and treatment objectives defined in short and long term time frames, and either dictated or handwritten neatly in the medical record.
- K. All orders for medical treatments shall be in writing by the responsible physician. In an emergency situation, verbal orders may be given to a registered nurse, but shall be signed by the ordering physician as soon as the emergency situation resolves. Telephone orders shall only be given to a registered nurse or other authorized licensed professional when the physician is not physically on the treatment unit, and shall be signed by the ordering physician within twenty-four (24) hours. When signing the orders the physician shall indicate the time and date of signing along with his/her name and degree.
- L. Medications used for patient treatment shall be approved for use by the Food and Drug Administration (FDA) for clinical use, and shall be listed in the approved organization formulary. Exceptions shall be requested in writing by the attending physician.
- M. Emergency services may be obtained at any time for a patient in the event of a sudden medical decompositions, by transferring the patient to a local medical facility per physicians' order. The attending physician shall follow the COBRA transfer requirements including the preparation of all necessary documents for transfer of care to a physician at the other facility.
- N. Members of the Medical Staff shall be responsible for maintaining accurate patient records per hospital policy. All entries in the medical record shall conform with applicable requirements and accept DWTC practices for documentation. Symbols and abbreviations used in the medical record shall be limited to those approved by the Medical Services Committee. Staff members shall respond to notices of documentation deficiencies, making indicated corrections within fifteen (15) days of notification.
- O. The attending psychiatrist on every patient shall complete a comprehensive discharge summary. This report shall contain a review of the patient's initial presentation, mental status examinations at admission and discharge, pertinent laboratory findings, diagnoses at admission and discharge, with an aftercare plan describing activity and dietary

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- recommendations or limitations, medications, psychiatric and medical follow up services, and housing/living arrangements. The discharge summary shall be completed and placed in the permanent medical record within ten (10) days from the day of discharge.
- P. Patients shall be discharged upon the order of the attending psychiatrist, on call psychiatrist, Medical Director, or his/her designee. At the time of discharge, the physician shall document the clinical condition of the patient, discharge diagnosis, and discharge medication(s) to be dispensed.
 - Q. As all medical records are the property of the facility, no original charts may leave the facility except with designated medical records personnel upon receipt of a valid court order. Copies may be made upon the signed consent of the patient and/or parent/legal custodian, or when court ordered to do so. During an admission, all previous and current medical records shall be available. The treatment team members, including the Medical Staff, should be familiar with the policies concerning medical records and patient confidentiality issues.
 - R. All Medical Staff members shall complete the required facility training concerning disaster situations and fire drills, fire extinguisher usage, infection control methods, risk management and safety factors, Medical Staff members shall participate in all DWTC disaster and fire drills.
 - S. All Medical Staff members shall become familiar with the Quality Control and Continuous Quality Improvement (CQI) Programs. Medical Staff members shall complete in not more than seven (7) days all requests for information related to the Quality Control and CQI functions; and shall participate in performance improvement activities as requested by the Medical Director.
 - T. All Medical Staff members shall have knowledge of current applicable Federal and State regulations; Department of Human Resources, Division of Child and Family Services, and DWTC Policies; and professional practice standards defined in the Nevada Revised Statutes.
 - U. All Medical Staff members shall maintain a current license to practice medicine in the State of Nevada, a Drug Enforcement Agency Controlled Substances Certificate, and a Nevada Board of Pharmacy Controlled Substance Certificate. The thirty (30) hour per biennium continuing education licensure requirement shall satisfy the DWTC medical education requirement.
 - V. All Medical Staff members shall report adverse medication reactions involving their patients per hospital policy. Similar untoward events shall be reported to the Medical Director using the DWTC incident reporting forms within one (1) hour of becoming aware of the adverse situation.
 - W. All Medical Staff members shall serve on the Medical Staff Committees as assigned by the Medical Director.
 - X. All Medical Staff members shall and remain current in their area of specialization.
 - Y. All Medical Staff members shall cooperate with patient death reviews.

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- Z. All Medical Staff members shall cooperate with the other DWTC employees, Department Heads, and colleagues. They shall also cooperate with representatives from other state agencies, including but not limited to alcohol substance abuse programs, Department of Prisons, Welfare, Public Health, police departments and other outside agencies.

Section 3: Autopsies

DWTC Medical Staff shall, as designated by the Medical Director, secure medical and psychological autopsies on all inpatient deaths. DWTC Policies for reporting shall be followed concerning psychological autopsies. The Medical Director or designee shall obtain the medical autopsy report from the County Coroner, along with toxicological studies, and prepare a death review which shall be forwarded to the DWTC Clinical Program Manager II. A Sentinel Event Review Committee shall be convened for all deaths that the Medical Director determines to be possible suicides. The Committee shall adhere to the DWTC Policy and established protocol in conducting the review, which shall encompass all clinical disciplines. The findings and recommendations of the review shall be communicated to the Medical Director, Medical Staff, including attending physician. DWTC Medical Staff, as designated by the Medical Director or his/her designee, will participate in Sentinel Event Root Cause Analysis. The findings and recommendations of Sentinel Event Root Cause Analysis shall be communicated to the Medical Director and the Medical Staff.

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Preamble

WHEREAS the Desert Willow Treatment Center (DWTC) is a public acute psychiatric Facility and Residential Treatment Center within Southern Nevada Child and Adolescent Services (SNCAS), organized under the laws of the State of Nevada within the Department of Health and Human Services (DHHS), Division of Child and Family Services (DCFS);

WHEREAS its purpose is to serve as a psychiatric treatment facility (henceforth referred to as Facility) providing client care, treatment and education of children and adolescents in Nevada;

WHEREAS it is recognized that the Local Governing Body (LGB) is responsible for assisting and supporting the Facility's mission, vision and organizational values;

WHEREAS it is recognized that the LGB is responsible for implementing a policy governing its own operation, management, and planning;

WHEREAS it is recognized that the LBG implements a plan for assessing, improving, and providing quality care;

WHEREAS it is recognized that the LGB serves as a liaison to other entities such as child serving agencies in Nevada communities, professional organizations involved in service delivery to children with serious emotional disturbances and health related issues, and charitable organizations interested in the well-being of children;

THEREFORE through the Administrator of DCFS and the identified members designated to serve this group, hereby organize themselves into a Governing Body in conformity with the Bylaws hereinafter stated.

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General Provisions

1. Mission
 - a. DWTC, as established by Nevada Revised Statute (NRS) 433B.110-130 inclusively, as carried out through the Nevada Department of Health and Human Services (DHHS), Division of Child and Family Services (DCFS), is to be maintained for the care and treatment of children and adolescents with severe emotional disturbance and acute psychiatric disorders.
2. Purpose/Role
 - a. The purpose of the Local Governing Board (LGB) of DWTC is to review and recommend policy, maintain quality client care and serve as liaison to other entities such as child serving agencies in Nevada communities, professional organizations involved in service delivery to children with serious emotional disturbances and health related issues, and charitable organizations interested in the well-being of children.
3. Membership of the Governing Body
 - a. Appointment Process
 - i. The Nominating Committee will meet and convene annually to identify a list of nominees to be voted on in the annual meeting. This committee shall also be convened for a special meeting to address vacancies of elected officers.
 - ii. The Nominating Committee will convene to prepare a list of prospective board members to present to the Administrator of DCFS for appointment.
 - iii. The DCFS Administrator, or designee, who is appointed by the Director of DHHS and confirmed by the Governor, appoints the membership of the Governing Body.
 - b. Composition
 - i. The LGB members shall consist of at least nine (9) but no more than thirteen (13) members. At least seven (7) of the nine (9) shall be voting members. The remaining members shall serve as ex-officio members with no voting privileges.
 - c. Term/Voting Activities
 - i. Members shall serve a term of two years, with no more than 50% of the membership expiring at one time as determined by a process decided upon by board members at its inception, and be composed of the following voting members:
 1. The Southern Deputy Administrator, DCFS, or designee who serves as the regional authority for DWTC;
 2. A Child/Family advocate;
 3. A member of the community at large;

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4. A member of the Southern Nevada Mental Health Consortium;
 5. Two (2) members who have family members that are clients that receive services from DCFS;
 6. Two (2) CMHDS Commissioners appointed by the Commission through the Administrator.
 7. Others, as recommended/invited by the Governing Body membership.
- ii. Ex-officio members who shall be non-voting include:
 1. The Facility Program Manager, DWTC;
 2. The Administrative Services Office (ASO), SNCAS;
 3. The Chief Medical Officer (CMO), DWTC;
 4. The Director of Nursing (DON), DWTC;
 5. The Quality Assurance Specialist (QAS), DWTC;
 6. A Deputy Attorney General (DAG);
 7. Others, as recommended/invited by the Governing Body membership.
- d. Conflict of Interest
- i. Members of the LGB, professional staff, or any agent or employee of DWTC/DCFS shall not have any undisclosed conflicts of interest with the Facility. The LGB, when made aware of a conflict of interest, shall thereupon determine, by majority vote, whether the disclosure shows that a conflict of interest exists or can reasonably be construed to exist. If a conflict is deemed to exist, such person shall not vote on, nor use his personal influence on, nor participate (other than to present factual information or to respond to questions) in the discussion of deliberations with respect to such contract or transaction. The minutes of the meeting shall reflect the disclosure made, the vote thereon, and where applicable, the abstention from voting and participation, and whether a quorum was present.
- f. Compensation
- i. LBG members shall receive no direct compensation for any services rendered in their duties as a LGB member or any other capacity (e.g., committees; workgroups; etc.).
 1. State classified staff will be permitted to work a variable work schedule to “flex” hours, accrued as a result of involvement with LGB, that exceed regularly scheduled hours per the DCFS Personnel Policy and Procedure Manual.
- g. Removal and Resignation
1. The Administrator, with or without cause, may remove a LGB member at any time.

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2. Any LGB member who has failed to attend 50% of the regularly scheduled meetings maybe also be removed by a two-third affirming vote.
- h. Relationships to stakeholders
- i. Relationship to Administrator of DCFS.
 1. The authority superior to the LGB is the Administrator of DCFS who is appointed by the Director of DHHS and confirmed by the Governor.
 - ii. Relationship to DWTC Program Manager.
 1. The Administrator of DCFS, or designee, is the appointing authority for the DWTC Facility Program Manager.
 2. The Facility Program Manager is employed by DCFS and shall meet the qualifications as specified in the State of Nevada personnel job classifications and will act in accordance with all state policies as defined in NRS; Nevada Administrative Code (NAC); and Prohibitions and Penalties.
 3. The Facility Program Manager shall serve as an ex-officio member of the LGB and attend meetings to discuss the roles, responsibilities and requirements of DWTC to the state of Nevada, DHHS, and DCFS for carrying out its mission.
 - iii. Relationship to SNCAS Medical Staff.
 1. The SNCAS Chief Medical Officer shall represent the DWTC medical staff on the LGB.
 2. Bylaws and minutes of the LGB shall be provided by the SNCAS Chief Medical Officer to the DWTC Medical Staff.
 3. The SNCAS Chief Medical Officer shall lead in the preparation of Medical Staff bylaws and present them to the LGB for approval.
 - iv. Relationship to the Commission on Mental Health Developmental Services (CMHDS).
 1. The LGB acknowledges that CMHDS' role in advising and overseeing matters related to Facility operations and client care as specified in NRS 433.314-327 inclusively.
 2. The LGB shall provide information to the CMHDS on matters related to the Facility in Accordance with Nevada law.
 - v. Governing Body Organizational Structure
 1. Appointment/Selection of Officers.
 - a. The Chairperson of the LGB shall be nominated and elected by voting members at

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the annual meeting and shall serve a term of one (1) year. The Chairperson must be elected by majority and may be re-elected.

1. DCFS staff shall not serve as the Chairperson.
 - b. The Vice-Chairperson of the LGB shall be nominated and elected by voting members at the annual meeting and shall serve a term of one (1) year. The Vice-Chairperson must be elected by majority and may be re-elected.
 1. DCFS staff shall not serve as the Vice-Chairperson.
 - c. The body shall have authority to elect other officers as identified by and voted on by the voting membership.
2. Responsibility of Officers.
- a. The Chairperson
 1. Shall ensure that all proceedings of the LGB comply with the open meeting law according to NRS 421.
 2. Shall preside at and be responsible for the agenda of all LGB meetings.
 3. Shall assure the formation of subcommittees and workgroups with chairpersons, as necessary.
 4. Shall receive and/or request all communications, recommendations, reports of activities, and records of actions on pertinent issues.
 5. Shall appoint a spokesperson for the LGB in its external professional and public relations.
 6. The Vice-Chairperson, in the absence of the Chairperson shall assume the duties of the Chairperson and may be asked to chair subcommittees and workgroups.
3. Procedures for LGB Meetings.
- a. The LGB shall establish a meeting schedule that meets no less than quarterly. Meetings are defined as:
 1. The annual meeting shall be held once a year, during which time voting will be used to address membership and to conduct routine business.

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- i. The LGB shall determine a date for the annual meeting.
 - ii. The annual meeting shall be held each year on the same date.
 2. Regular meetings shall be held at least quarterly in addition to the annual meeting.
 3. Special meetings may be held at the request of any three members at any time and shall comply with the open meeting law. The business to be carried out at any special meeting shall concern those items identified within the request for the special meeting.
 - b. The LGB shall keep written minutes. The minutes shall be tape recorded or transcribed records from a certified court reporter. These minutes must be publicly posted at the agency and on the DCFS website.
 - c. Meetings are conducted in accordance with Robert's Rules of Order.
 - d. A quorum shall consist of 51% of voting members present.
 - e. The LGB must be in compliance with Nevada's Open Meeting Law, NRS 241, which includes a staff person designated by the LGB who shall be responsible for posting the agendas and identified materials, including the website, for the meetings three (3) days prior to each scheduled meeting.
4. Duties and Responsibilities of the LGB shall include:
- a. Review, and amend the DWTC LGB Bylaws biennially or more frequently, if needed.
 - b. Ensure that all members of the LGB are provided with an orientation to DWTC.
 - c. All members of the LGB shall annually participate in at least one DCFS training (e.g., conference; in-service training).
 - d. Provide for ongoing, effective communication between the LGB, the Facility Program Manager and the DWTC Staff.
 - e. Establish auxiliary or volunteer service organizations.
 - f. Evaluate the performance of the LGB and its membership annually.

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- g. Ensure full disclosure of involvement/ownership with outside entities as required by statutes and various accrediting/oversight agencies.
- h. Participate in accreditation, certification and licensure processes and be available to attend summation and or exit conferences.
- i. Evaluate the Facility's performance in relation to its vision, mission and goals annually and prepare a written report for the DCFS Administrator that may include but not be limited to recommendations regarding fiscal and human resources required by DWTC for effective functioning.
- j. Ensure full implementation of the DWTC's Quality Assurance and Performance Improvement Plan and provide feedback to Facility departments and teams regarding improvement activities. Request information as needed to monitor the status of individual projects.
- k. Participate in the Facility planning process by review of and comments on: the Strategic Plan process; the Quality Assurance and Performance Improvement Plan; Budget Operating Plans; and the Plan for Client Care.
- l. Review all DWTC reports (e.g., Human Resources Annual Competency; Quality Assessment and Performance Improvement; Patient Safety; Utilization Management; Risk Management and others as required.
- m. Identify and make recommendations that the necessary resources are available to provide appropriate and adequate services to the individuals served.
- n. Make recommendations to the Facility Program Manager to assist in compliance with all applicable laws and accrediting/regulatory standards.
- o. Review and approve the Medical Staff Bylaws and the Medical Staff Rules and Regulations.
- p. Support the Medical Staff by:
 - 1. Reviewing credentials and providing feedback on individual privileges.

**Assignment: Desert Willow Treatment Center Governing Board and Bylaws
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2. Reviewing individuals for Medical Staff membership.
3. Reviewing determinations concerning individual credentials and privileges.
4. Providing support and consultation regarding the mechanism for which membership of the Medical Staff may be terminated.
5. Providing support and consultation regarding the mechanism for fair hearing procedures at the medical executive committee level.
6. Providing support and consultation regarding the development of a process for appeals of Medical Executive Committee credentialing and privileging decisions.
7. Ensuring the Medical Staff develops bylaws, consistent with legal and other requirements, and reviews and approves the bylaws consistent with Facility policies and procedures.

Assignment: Desert Willow Treatment Center Governing Board and Bylaws
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APPROVAL AND ADOPTION:

Chairperson, Local Governing Board

Date

Vice Chair, Local Governing Board

Date

Reviewed and Approved:

Jone M. Bosworth, J.D.
Administrator, Division of Child and Family Services

Date

