MEDICAL CENTER

BYLAWS OF THE MEDICAL STAFF

PREAMBLE

WHEREAS, Saint Alphonsus Regional Medical Center is a nonprofit corporation organized under the laws of the State of Idaho with the purpose of providing patient care, education and research; and

WHEREAS, the goal of the Board and the Medical Staff is to strive for quality medical care in the Hospital; and

WHEREAS, the Board wishes to delegate to the Medical Staff, the overall responsibility for monitoring the quality of medical care in the Hospital and reporting and accounting to the Board, and delegate the authority and responsibility to make recommendations to the Board concerning an Applicant's appointment or reappointment to the Medical Staff of the Hospital and the Clinical Privileges such Applicant will enjoy in the Hospital; and

WHEREAS, the cooperative efforts of the Medical Staff, the Board and the Hospital administration are necessary to provide quality medical care to patients in the Hospital;

THEREFORE, to discharge these duties and responsibilities to the Hospital in an orderly fashion the physicians, dentists and independent practitioners practicing in the Hospital will function and act in accordance with the Medical Staff Bylaws and Organization Manual (Chapter 1), approved by the Medical Staff and the Board, and the Policy and Plans, Organization Manual (except Chapter 1) and other policies and procedures approved by the Medical Executive Committee and the Board.
ARTICLE I. MEDICAL STAFF MEMBERSHIP
Section 1. Purpose 6
Section 2. Nature of Medical Staff Membership 6
Section 3. Basic Qualifications for Membership 6
Section 4. Nondiscrimination 7
Section 5. Conditions and Duration of Appointment 7
Section 6. Medical Staff Dues 8
Section 7. Responsibilities of Each Member 8
Section 8. Medical Staff Member and Practitioner Rights and Conflict Resolution 9

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF
Section 1. Active Staff 11
Section 2. Courtesy Staff 11
Section 3. Affiliate Staff 12
Section 4. Affiliate Consulting 12
Section 5. Medical Associates 13
Section 6. Honorary Staff 13
Section 7. Locum Tenens Staff 13
Section 8. Ambulatory Staff 14
Section 9. Telemedicine 14
Section 10. Limitations of Prerogatives 15
Section 11. Provisional Period 16

ARTICLE III. OFFICERS
Section 1. Officers of the Medical Staff 17
Section 2. Qualifications of Officers 17
Section 3. Election of Officers 17
Section 4. Term of Office 17
Section 5. Vacancies of Office 18
Section 6. Duties of Officers 18
Section 7. Removal from Office 18

ARTICLE IV. MEDICAL STAFF ORGANIZATION
Section 1. Organization of the Medical Staff 19
Section 2. Department Chair and Chair-Elect 19
Section 3. Functions of Department Chair and Chair-Elect 21
Section 4. Assignment to Department 21
ARTICLE V. COMMITTEES
   Section 1. Designation and Substitution
   Section 2. Medical Executive Committee
   Section 3. Credentials Committee
   Section 4. Bylaws Committee
   Section 5. Additional Committees

ARTICLE VI. MEETINGS
   Section 1. Annual and Special Medical Staff Meetings
   Section 2. Department, Committee and Clinical Section Meetings
   Section 3. Provisions Common to all Meetings

ARTICLE VII. GENERAL PROVISIONS
   Section 1. Exclusive Services
   Section 2. Compliance with Applicable Laws
   Section 3. Confidentiality
   Section 4. History and Physical Requirements
   Section 5. Conflict of Interest

ARTICLE VIII. APPLICATION PROCESS FOR INITIAL APPOINTMENT AND
    DELINEATION OF CLINICAL PRIVILEGES
   Section 1. Policy
   Section 2. Request for Application
   Section 3. Application Process
   Section 4. Credentialing Procedure
   Section 5. Time Periods for Processing

ARTICLE IX. REAPPOINTMENT PROCESS
   Section 1. Reappointment Form
   Section 2. Content of Reappointment Form
   Section 3. Verification of Information
   Section 4. Reappointment Duration
   Section 5. Department Action
   Section 6. Credentials Committee Action
   Section 7. Medical Executive Committee Action
   Section 8. Final Processing and Board Action

ARTICLE X. TEMPORARY PRIVILEGES
   Section 1. Conditions for Temporary Clinical Privileges
   Section 2. Approval of Temporary Clinical Privileges
   Section 3. Denial or Termination of Temporary Clinical Privileges
   Section 4. Application Process for Locum Tenens Applicants

ARTICLE XI. EMERGENCY AND ORGAN HARVESTING PRIVILEGES
   Section 1. Emergency Privileges
   Section 2. Organ Harvesting Teams
   Section 3. Disaster Privileges
ARTICLE XII. PRIVILEGING
Section 1. Basis for Privileges 48
Section 2. Uniform Application of Privileging Determination 48

ARTICLE XIII. PROCESS FOR THE DEVELOPMENT OF PRIVILEGING CRITERIA
Section 1. Purpose 49
Section 2. Policy 49
Section 3. Procedures for Development of Privileging Criteria 49

ARTICLE XIV. IMPAIRED PHYSICIANS
Section 1. Purpose 52
Section 2. Definition 52
Section 3. Procedure for Report and Investigation 52
Section 4. Classification of Impairment 53
Section 5. Recommendation 53
Section 6. Communication of Investigation 53
Section 7. Confidentiality/Documentation of Investigation 53
Section 8. No Abuse of Policy 53
Section 9. Impairment Classified as a Disability Under ADA 54
Section 10. Impairments that are not Disabilities Under ADA 54
Section 11. Rehabilitation and Reinstatement 55
Section 12. After-Care Programs 55

ARTICLE XV. CONDUCT
Section 1. Purpose and Philosophy Statement 56
Section 2. Definitions 56
Section 3. Scope of Policy 57
Section 4. Procedures for Documenting and Triaging Event Reports/Complaints 57
Section 5. Further Evaluation of Report/Complaint 58
Section 6. Final Meeting with the Practitioner and Communication of Findings 60
Section 7. Remedial Options for Policy Violations 60
Section 8. No Abuse of Policy Tolerated 61
Section 9. No Retaliation Policy 61
Section 10. Reappointment 61

ARTICLE XVI. CORRECTIVE ACTION
Section 1. Investigation Procedures 62
Section 2. Procedure Following Completion of Investigation 63
Section 3. Adverse Recommendations 63
Section 4. Non-Adverse Recommendations 64
Section 5. Suspension for Purposes of Investigation 64
Section 6. Suspension for Reasons of Patient Safety 64
Section 7. Automatic Suspension and Voluntary Relinquishment of Clinical Privileges 65
Section 8. Care of Practitioner's Patients with Automatic Suspension or Voluntary Relinquishment of Privileges 66
Section 9. No Procedural Rights 66
ARTICLE XVII. FAIR HEARING
Section 1. Initiation Of and Right to Hearing 67
Section 2. Limitations on Hearing Rights 67
Section 3. Notice of Recommendation and Practitioner Rights for Hearing 68
Section 4. Appointment of the Hearing 68
Section 5. Time and Place for Hearing 68
Section 6. Exchange of Witness and Exhibit Lists 68
Section 7. Postponement and Extensions 69
Section 8. Hearing Procedure 69
Section 9. The Hearing Officer 69
Section 10. The Presiding Officer 69
Section 11. Record of Hearing 70
Section 12. Rights of Both Sides 70
Section 13. Admissibility of Evidence 70
Section 14. Official Notice 70
Section 15. Memorandum of Points and Authorities 71
Section 16. Adjournment and Conclusion 71
Section 17. Burden of Proof 71
Section 18. Basis of Decision 71
Section 19. Post-Hearing Procedure 71
Section 20. Appeal 72
Section 21. Reporting 73
Section 22. Construction with the Health Care Quality Improvement Act 73

ARTICLE XVIII. AMENDMENT PROCEDURES
Section 1. Medical Staff Responsibility 74
Section 2. Methods of Bylaws Adoption and Amendment 74
Section 3. Other Medical Staff Policies and Procedures 74

ARTICLE XIX. ADOPTION 76
MEDICAL STAFF MEMBERSHIP

ARTICLE I

SECTION 1. PURPOSE

1. The purpose of this Medical Staff is to bring qualified physicians, dentists, and independent practitioners who practice at Saint Alphonsus Regional Medical Center together into a cohesive body to promote excellent care and to offer advice, recommendations, and input to the Chief Executive Officer and the Board.

SECTION 2. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of Saint Alphonsus Regional Medical Center is a privilege which will be extended only to professionally competent practitioners who continuously meet the qualifications and responsibilities set forth in these Bylaws, and the requirements set forth in the Medical Staff Policy and Plans and other policies and procedures of the Medical Staff and Hospital.

SECTION 3. BASIC QUALIFICATIONS FOR MEMBERSHIP

A. MINIMUM QUALIFICATIONS: The following minimum qualifications must be met by all Applicants for appointment to the Medical Staff before an application will be processed and must be continuously met to maintain Medical Staff Membership:

1. Hold current unrestricted licensure to practice in the State of Idaho as a physician, dentist, or independent practitioner;
2. Possess relevant education, training, experience and excellent judgment;
3. Demonstrate clinical performance and current competence with either (a) An active clinical practice for the last twelve (12) months, or, (b) A previous active clinical practice combined with an intensified provisional period, as outlined in the Article VIII, Section 4.M., or, (c) Have recently completed a training program (internship, residency or residency review);
(d) If seeking locum tenens status, has provided locums coverage for at least forty (40) days within the past six (6) months.
4. Demonstrate the ability to safely and competently exercise any clinical privileges requested with or without reasonable accommodation;
5. Hold current, valid federal and state controlled substance certificate (if applicable to practice/specialty);
6. Demonstrate compliance with the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops, the ethics of his/her profession, and the mission and philosophy of the Hospital;
7. Demonstrate his or her good reputation and character and his or her ability to work harmoniously with others;
8. Provide appropriate response time to the Hospital by residing and practicing within an appropriately close geographical distance;
9. Maintain continuous management of his or her patients;
10. Possess good communication skills;
11. Possess current professional liability insurance of a type and in an amount established.
12. Medical Doctor or Doctor of Osteopathic Medicine must have successfully completed a residency training program and/or fellowship recognized by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) in the specialty for which he or she is applying for Privileges; be Board certified by the 7th year after joining the Medical Staff by one of the American Board of Medical Specialties (ABMS) specialty boards, the American Osteopathic Association specialty boards, the National Board of Physicians and Surgeons (NBPAS), the American Board of Physician Specialties (ABPS), the American Board of Foot and Ankle Surgery (ABFAS), or the American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS) as appropriate in the specialty for which he or she is applying for Privileges, and continuously maintain such board certification thereafter;

13. Possess a record that is free of a criminal history for the past three (3) years including felony convictions, and including exclusion from participation in Medicare/Medicaid; and
14. Comply with applicable continuing medical education requirements as set forth in the Medical Staff Policy & Plans.

B. EXCEPTIONS
   1. All Medical Staff Members as of 01/01/2002, who met prior qualifications for membership will be exempt from Board certification and re-certification requirements, stated in Article I, Section 3(A)(12) above.
   2. All other exceptions to the above may be granted only by the Board after a meeting between representatives of the Board and the physician members of the Medical Executive Committee.

C. ENTITLEMENTS
   1. No entitlement to membership or privileges by virtue of other membership or privileges.
   2. No practitioner will be entitled to membership on the Medical Staff or to exercise particular clinical privileges merely by virtue of his or her licensure, prior practice, membership in any professional organization, or clinical privileges at any other healthcare organization.

SECTION 4. NONDISCRIMINATION

The Hospital will not unlawfully discriminate in granting medical staff membership and/or clinical privileges on the basis of ancestry, race, gender, national origin, faith, age or disability unrelated to the provision of patient care.

SECTION 5. CONDITIONS AND DURATION OF APPOINTMENT

A. INITIAL APPOINTMENT
   1. The Board will make initial appointment and reappointment to the Medical Staff.
   2. The Board will act on appointments and reappointments only after there has been a recommendation from the Medical Executive Committee.

B. DURATION OF APPOINTMENT
   Appointments to the Medical Staff will be for no more than twenty-four (24) calendar months.
SECTION 6. MEDICAL STAFF DUES

Annual Medical Staff dues will be determined by the most recent action that has been recommended by the Medical Executive Committee and adopted at a regular or special Medical Staff meeting. The Office of Medical Affairs will notify each Medical Staff member in writing of any contemplated change in Medical Staff dues at least thirty (30) days before the meeting at which voting on such proposed changes is to take place. Dues will be due and payable upon request. Failure to pay dues within ninety (90) days of receipt of the request for payment will be deemed a voluntary relinquishment of Medical Staff membership and privileges until such dues and fines, if any, are paid in full. Department Chairs, members of the Bylaws, Physician Professional Practice, and Peer Review & Quality Committees, are exempt from paying dues.

SECTION 7. RESPONSIBILITIES OF EACH MEMBER

A. RESPONSIBILITIES • Each Medical Staff Member must fulfill the following responsibilities:
   1. Personally provide appropriate, timely and continuous care of his or her patients and arrange coverage by another Medical Staff member in the event of illness, travel, vacation or other activities which may interfere with continuous care of his/her patients.
   2. Prepare timely, legible and complete medical and other required records for all patients he or she admits or for whom he or she in any way provides care in the Hospital or other health care setting;
   3. Participate in the emergency on call coverage and other call coverage programs as set forth in the Medical Staff Policy and Plans and Organization Manual;
   4. Abide by the Bylaws, Medical Staff Policy and Plans, and other policies and procedures of the Medical Staff and the Hospital, and the Ethical and Religious Directives for Catholic Health Care Services with respect to clinical work and other activities within the Hospital;
   5. Pay all Medical Staff dues and assessments in a timely manner;
   6. Notify the Office of Medical Affairs in writing within ten (10) days of unscheduled changes in medical staff status or privileges at any hospital where membership is held, and provide notification of the reason for such change;
   7. Assist the Hospital in the fulfillment of its mission;
   8. Contribute to the organizational and administrative affairs of the Medical Staff;
   9. Actively participate in recognized functions of Medical Staff appointment including quality/performance improvement, risk management and monitoring activities, including monitoring of new appointees during the provisional period and in discharging other Medical Staff functions as may be required from time to time;
   10. Mandatory participation in Peer Review activities as necessary and requested and as outlined in the Bylaws and Performance and Peer Review Policy. Attendance is used as part of the reappointment review process.
   11. Abide by the applicable provisions of the Hospital’s Organizational Integrity Program (“OIP”) or any compliance plan under which it is subsequently operating, including its Standards of Conduct and Policies;
   12. Maintain the confidentiality of all peer review, quality assurance and patient care activities;
   13. Disclose to the appropriate department chair or the Credentials Committee chair, any information personally known by the Member concerning an Applicant and/or Member which would call into question the ability of the Applicant or Member to provide quality
care or which would raise questions about the morals or professional ethics of the Applicant or Member;

14. Provide the Hospital and Medical Staff with his or her current mailing, street address and email address.

SECTION 8. MEDICAL STAFF MEMBER AND PRACTITIONER RIGHTS AND CONFLICT RESOLUTION

A. AUDIENCE WITH MEDICAL EXECUTIVE COMMITTEE. • Each Medical Staff Member has the right to an audience with the Medical Executive Committee, if a Medical Staff Member is unable to resolve a difficulty by first working in good faith for a reasonable time under the circumstances with his/her respective department chair. In such event a Medical Staff Member may, upon presentation of a written notice to the President of the Medical Staff, meet with the Medical Executive Committee to discuss the issue at its next scheduled meeting. The provisions of this Article I, Section 8, Paragraph A will not apply to Medical Staff Member matters which either could be or are in fact being addressed through Corrective Action or Fair Hearing.

B. DEPARTMENT MEETING. • Any Medical Staff Member may request a department meeting by a written request to the President of the Medical Staff signed by a majority of the department members, setting forth the reason for the request.

C. POLICY CHALLENGE. • Any Medical Staff Member may raise a challenge to any policy established by the Medical Executive Committee. In the event that a policy is felt to be inappropriate, any Medical Staff Member may submit a petition to the President of the Medical Staff signed by ten percent (10%) of the Active Medical Staff Members. The President will forward the petition to the Medical Executive Committee at its next scheduled meeting. When such petition has been received by the Medical Executive Committee, it will either (1) provide the petitioners with information clarifying the intent of such policy, and/or (2) schedule a meeting with the petitioners to discuss the issues.

D. GENERAL MEDICAL STAFF MEETING. • Any Medical Staff Member may call a general Medical Staff meeting. If a petition signed by fifteen percent (15%) of the Members of the Active Medical Staff is presented to the President, the President will forward the petition to the Medical Executive Committee at its next scheduled meeting. The Medical Executive Committee will schedule a general Medical Staff meeting for the specific purpose addressed by the petitioners. No business other than that detailed in the petition may be transacted at the general Medical Staff meeting.

E. RECALL ELECTION. • Any Medical Staff Member has the right to initiate a recall election of a Medical Staff officer and/or department chair as set forth in these Bylaws, Article III, Section 7 and Article IV, Section 2.

F. EXCLUSIONS. • The above Paragraphs A-E do not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileging. The Fair Hearing section outlines matters for which a hearing/appeal is available and the procedure for such hearing and appeal.
HEARING/APPEAL • Any Practitioner has a right to a hearing/appeal pursuant to the Medical Staff’s Fair Hearing section of these Bylaws.

G. VOLUNTARY OR AUTOMATIC RELINQUISHMENT • Voluntary or automatic relinquishment of appointment or clinical privileges or the precautionary suspension of clinical privileges as provided in these Bylaws or the Fair Hearing Plan or Corrective Action Plan will not constitute grounds for a hearing.
ARTICLE II

CATEGORIES OF THE MEDICAL STAFF

SECTION 1. ACTIVE STAFF

A. QUALIFICATIONS • Appointees to the category must:
   1. Meet the Basic Qualifications for Membership outlined in Article I, Section 3, and satisfy the Responsibilities of Each Member outlined in Article I, Section 7; and
   2. Be a physician or a dentist.

B. PREROGATIVES • Appointees to this category may:
   1. Admit patients and exercise such clinical privileges as are granted by the Board;
   2. Attend meetings of the Medical Staff and of the department of which he/she is a member, and any Medical Staff or Hospital education programs;
   3. Vote on all matters presented by the Medical Staff and by the appropriate department and committees of which he or she is a member; and
   4. Be elected to hold office and be appointed to sit on or be the chairperson of any committee, unless otherwise specified elsewhere in these Bylaws.

C. Volume Requirements • Within the first nine (9) months on staff (FPPE/Provisional period) the appointee must have treated at least six (6) patients or have performed at least six (6) procedures or consultations at Saint Alphonsus Regional Medical Center.

Hospice Care/Palliative Providers are exempt from volume requirements.

SECTION 2. COURTESY STAFF

The Courtesy Staff will consist of those physicians and dentists who do not regularly use the Hospital but desire to be associated with the Hospital and occasionally wish to admit patients, occasionally consult on patients, or occasionally use the Hospital’s outpatient diagnostic and therapeutic services. Courtesy Staff will include physicians and dentists practicing via telemedicine and those practicing solely in an outpatient setting. However, such physicians and dentists are required to meet the qualifications and follow the other provisions set forth in the Telemedicine and non-Hospital Based policies.

A. QUALIFICATIONS • Appointees to this category must:

   1. Meet the Basic Qualifications for Membership in Article I, Section 3 with the exception of paragraph 8 and satisfy the Responsibilities of each Member outlined in Article I, Section 7 with the exception of paragraph 3.

B. PREROGATIVES • Appointees to this category may:

   1. Admit patients, consult on patients and exercise such clinical privileges as are granted by the Board, including surgical assisting, no more than six (6) times per year, after which the physician or dentist will no longer meet the Qualifications for Courtesy Staff and will be automatically placed on the Active Staff, if he or she meets the Qualifications for Active
Staff; and

2. Attend meetings of the Medical Staff and department of which he or she is a member and any Medical Staff or Hospital education programs.

C. **Volume Requirements** • Within the first nine (9) months on staff (FPPE/Provisional period) the appointee must have treated at least three (3) patients or have performed at least three (3) procedures or consultations at Saint Alphonsus Regional Medical Center.

Hospice Care/Palliative Providers are exempt of volume requirements.

**SECTION 3. AFFILIATE STAFF**

The Affiliate Staff will consist of those Medical Staff members who desire to be associated with the Hospital, but who do not intend to establish a practice at this Hospital. The primary purpose of Affiliate Staff is to promote professional and educational opportunities, including continuing medical education endeavors, and to permit such individuals to access Hospital services for their patients by direct referral of patients to other members of the staff for admission, evaluation, and/or care and treatment.

A. **QUALIFICATIONS** • Appointees to this category must:

1. Meet the Basic Qualifications for Membership outlined in Article I, Section 3 with the exception of Paragraphs 8 and 9, and satisfy the Basic Responsibilities of Each Member in Article I, Section 7, with the exception of paragraph 3.

B. **PREROGATIVES** • Appointees to this category:

1. Will be granted no clinical privileges, with the exception of surgical assisting privileges if granted by the Board;
2. May visit their hospitalized patients and review their hospital records but will not be permitted to admit patients, to attend patients, to exercise any clinical privileges, to write orders or progress notes, to make notations in the medical record or to actively participate in the provision of care or management of patients in the Hospital; and are encouraged to attend educational programs sponsored by the Hospital.

**SECTION 4. AFFILIATE CONSULTING**

The Affiliate Consulting Staff consists of Physicians who are specialists willing to serve in a consulting capacity. Members of the Affiliate Consulting Staff shall provide their services in the care of patients whenever reasonably possible on request of any member of the Active or Courtesy Staff.

A. **QUALIFICATIONS** • Appointees to this category must:

1. Meet the Basic Qualifications for Membership outlined in Article I, Section 3 with the exception of Paragraphs 8 and 9, and satisfy the Basic Responsibilities of Each Member in Article I, Section 7 with the exception of Paragraph 3.

B. **PREROGATIVES** • Appointees to this category:

1. Exercise consulting privileges and surgical assisting privileges if granted by the Board. Affiliate Consulting Staff will not be granted admitting privileges.
2. Visit their hospitalized patients and review their hospital records and provide consultations.
3. Attend Medical Staff meetings, but are not required to do so and are not eligible to hold a Medical Staff office.

SECTION 5. MEDICAL ASSOCIATES

A. QUALIFICATIONS • The Medical Associate Staff will consist of Independent Practitioners (Podiatrists and Psychologists)

Appointees to this category must:
1. Meet the Basic Qualifications for Membership outlined in Article I, Section 3, with the exception of A.12 for psychologists and A.1 for Clinical Neurophysiologists, and meet the Basic Responsibilities of Each Member required by Article I, Section 7, with the exception of the on-call requirements in Paragraph A.3,
2. Be a Podiatrist or Psychologist; and
3. Psychologists must have graduated from an American Psychological Association (APA) program.

B. PREROGATIVES • Medical Associates may exercise clinical privileges approved by the Board.

C. VOLUME REQUIREMENTS • Within the first nine (9) months on staff (FPPE/Provisional period) the appointee must have treated at least six (6) patients or have performed at least six (6) procedures or consultations at Saint Alphonsus Regional Medical Center.

SECTION 6. HONORARY STAFF

The Honorary Staff category will consist of individuals that the Board and Medical Staff wish to honor. Such Medical Staff appointees are not eligible for Clinical Privileges. They may attend Medical Staff Department meetings, continuing medical education activities, and may be appointed to committees.

SECTION 7. LOCUM TENENS STAFF

The Locum Tenens Staff will consist of those physicians who are filling in for a physician or are filling an unmet patient care need at the Hospital temporarily.

A. QUALIFICATIONS • Appointees to this category must:
1. Meet the Basic Qualifications for Membership in Article I, Section 3 with the exception of paragraph 8 and satisfy the Responsibilities of Each Member outlined in Article I, Section 7 with the exception of paragraphs 3, 5 and 10.

B. PREROGATIVES • Appointees to this category may:
1. Admit patients, consult on patients and exercise such clinical privileges as are granted by the Board.
2. Locum tenens physicians’ privileges will be approved for no more than one year. If the locum tenens physician will be returning to cover additional dates after the one year period, the physician will need to reapply for membership and privileges.
SECTION 8. AMBULATORY STAFF

A. QUALIFICATIONS • Appointees to this category must:
   1. Be an outpatient care physician. For the purposes of the Ambulatory Staff Category, "outpatient care physician" includes all physicians who work in the outpatient setting exclusively.

   2. Meet the Basic Qualifications for Membership in Article I, Section 3 with the exception of item 8, and satisfy the Basic Responsibilities of Each Member in Article I, Section 7, with the exception of item 3.

B. PREROGATIVES • Appointees to this category may:
   1. Exercise such clinical privileges as are granted by the Board;
   2. Attend meetings of the Medical Staff and of the Ambulatory department of which he/she is a member, and any Hospital education programs;

SECTION 9. TELEMEDICINE

Practitioners applying to the Saint Alphonsus Medical Staff for the purpose of providing medical care to patients being diagnosed and/or treated at the Hospital, through telemedicine, will be required to comply with the Basic Qualifications for Membership (Bylaws, Article I, Section 3) except:

A. SUBSECTION A 8 • Provide appropriate response time to the Hospital by residing and practicing within an appropriately close geographic area; and

B. SUBSECTION A 9 • Provide continuous management of their patients.

Practitioners providing medical care to patients being diagnosed and/or treated at the Hospital, through telemedicine, will also be required to comply with the Responsibilities of Each Member (Bylaws, Article I, Section 7) except:

A. SUBSECTION A.3 • Participate in emergency call coverage and other coverage programs as set forth in the Medical Staff Policy and Plans and Organization Manual; and

B. SUBSECTION A.10 • Fulfill any meeting attendance requirements as established by the Medical Staff.

PREROGATIVES

Practitioner’s applying to the Medical Staff to provide medical care through telemedicine will be subjected to the same credentialing standards as Medical Staff Members providing hands on medical care.

SCOPE OF SERVICES

Each department will establish an appropriate privilege list for telemedicine practitioners taking into consideration the limitations associated with the telemedicine equipment.

TELEMEDICINE CREDENTIALING AND PRIVILEGING

Centers for Medicare and Medicaid (CMS) allow for a process for originating site hospitals (location of the patient) to rely on the credentialing and privileging decisions of the distant site hospital (location of the specialist) for practitioners providing services via telemedicine.
In order for the originating site [Saint Alphonsus] to utilize credentialing and privileging information from the distant site in credentialing and privileging decisions, the following conditions must be met:

- The distant site must be Joint Commission (TJC) accredited and a Medicare participating hospital;
- The practitioner must be currently privileged at the distant site for the services to be provided at the Saint Alphonsus and provide a current list of the practitioner’s privileges;
- The distant site practitioner holds a current state issued license in the state where Saint Alphonsus hospital is located;
- A current agreement must be in place between the Saint Alphonsus and the distant site which clearly describes in detail, credentialing and privileging procedures that meet or exceed the same standards as Saint Alphonsus Medical Staff Members providing hands on medical care and,
- Saint Alphonsus must have evidence of an internal review of the practitioner’s performance of their privileges and sends information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events, considered reviewable by the TJC that result from the telemedicine services provided and complaints from patients, other practitioners, or staff.

Additionally, remote sites may rely on Saint Alphonsus credentialing within the limits of TJC and CMS rule with current agreement in place.

**Peer Review and Quality Data**

Practitioners providing medical care through telemedicine will be required to submit practitioner specific and associated aggregate data to their department for appointment, advancement and reappointment when, in the department chair’s opinion, there is insufficient information to make a judgment on current clinical competence.

1 For the purpose of this Chapter, the Hospital refers to all Saint Alphonsus, Inc., health care facilities where the practitioners are required to be credentialed and privileged by and through the Saint Alphonsus Regional Medical Center’s Office of Medical Affairs.

**Section 10. Limitations of Prerogatives**

The Prerogatives set forth under each Medical Staff category in this Article II are general in nature and may be subject to limitations by special conditions attached to a Practitioner’s Membership, by other Sections of these Bylaws, the Policy and Plans of the Medical Staff and other policies or procedures of the Medical Staff.

**Section 11. Provisional Period**

All initial appointments to the Medical Staff will be provisional as set forth in the Bylaws, Article VIII, Section 4.K.
ARTICLE III

OFFICERS

SECTION 1. OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff will consist of the following:

A. PRESIDENT;

B. PRESIDENT ELECT; and

C. SECRETARY/TREASURER.

SECTION 2. QUALIFICATIONS OF OFFICERS

Officers must be Active Medical Staff members in good standing, have previously served in a significant capacity, indicate a willingness and ability to serve, have excellent administrative and communication skills, and be certified by a specialty Board. Officers may not simultaneously be an officer or a department chair at another hospital.

SECTION 3. ELECTION OF OFFICERS

A. ELECTIONS • Officers will be elected at the Annual Meeting of the Medical Staff by a majority vote of eligible votes cast by those present. Only Members of the Active Medical Staff category will be eligible to vote. The President of the Medical Staff’s vote will be withheld and counted only in the case of a tie vote. Two weeks prior to the election, absentee ballots will be available to those people who personally come to the Office of Medical Affairs and sign for the ballot. All officers will be confirmed by the Board.

B. NOMINATIONS •

1. Nominations for Officers will be promulgated by a nominating committee consisting of the President, immediate past three (3) Presidents and the current chair of the Credentials Committee. Write-in candidates must notify the Nominating Committee at least twenty (20) days in advance of the Annual Meeting of the Medical Staff of their intention to pursue an office including their platforms and biographical data. Nomination must be announced, and the names of the nominees distributed to all Members of the Active Medical Staff at least thirty (30) days prior to the election. A sample ballot will be distributed to the Medical Staff at least fourteen (14) days prior to the elections with platforms and biographical data.

2. Nominations may also be made by a petition signed by at least ten percent (10%) of the Active Medical Staff. Such petition must be submitted to the President at least fourteen (14) days prior to the election.

SECTION 4. TERM OF OFFICE

All officers serve a term of two (2) years. The President Elect of the Medical Staff will automatically assume the office of President at the end of his term. Officers will assume office following their election at the Annual Meeting of the Medical Staff. Election will be effective
as soon as approved by the Board.

SECTION 5. VACANCIES OF OFFICE

If there is a vacancy in the office of the President, the President Elect will serve the remainder of the term. If there is a vacancy in the office of President Elect, a new election will be held according to the procedure set forth in these Bylaws. Vacancies in other offices of the Medical Staff will be filled by the Medical Executive Committee, pending a general Medical Staff election.

SECTION 6. DUTIES OF OFFICERS

Officers of the Medical Staff will have such duties as set forth in the Organization Manual.

SECTION 7. REMOVAL FROM OFFICE

A. REASONS FOR REMOVAL • Officers may be removed from office for reasons including but not limited to the following:
   1. Failure to conduct those responsibilities assigned within these Bylaws, the Policy and Plans of the Medical Staff or policies and procedures of the Medical Staff;
   2. For having an automatic or precautionary suspension; and/or
   3. For conduct damaging to the Hospital, its goals, or programs.

B. REMOVAL BY BOARD • The Board may remove from office any officer on its own initiative but only after a meeting between representatives of the Board and the physician members of the Medical Executive Committee. The reason for such removal must be related to the execution of duties and must violate these Bylaws or for reasons as identified in paragraph A of this section of the Bylaws. The affected individual will not be present at that meeting.

C. REMOVAL BY THE MEDICAL STAFF • The Medical Staff may initiate the process for removal of any officer by petition of twenty percent (20%) of the entire Active Medical Staff. If a valid petition is presented to the President of the Medical Staff, he or she will forward the petition to the Medical Executive Committee at its next scheduled meeting. If the President is the subject of the recall petition, the petition will be presented to the President Elect or Secretary/Treasurer who will present it to the Medical Executive Committee at its next scheduled meeting. The Medical Executive Committee will schedule a special general Medical Staff meeting for purposes of discussing and voting on the issue. An officer may be removed by a two-thirds (2/3) affirmative vote of those voting members present at the meeting.
ARTICLE IV  MEDICAL STAFF ORGANIZATION

SECTION 1. ORGANIZATION OF THE MEDICAL STAFF

A. DEPARTMENTS • The Medical Staff of the Hospital will be organized into Departments. Each Department will have a chair and chair-elect with overall responsibility for the supervision and satisfactory discharge of assigned functions. Departments are listed in and will perform the functions set forth in the Organization Manual.

B. CLINICAL SECTIONS • The Medical Executive Committee may recognize any group of practitioners who wish to organize themselves into a Clinical Section. The functions and activities of such Clinical Section are set forth in the Policy and Plans of the Medical Staff and the Organization Manual.

SECTION 2. DEPARTMENT CHAIR AND CHAIR ELECT

A. QUALIFICATIONS • All department officers must be members of the Active or Active Ambulatory Medical Staff and certified by an appropriate specialty board or have affirmatively established comparable competence through the privilege delineation process.

B. DUTIES • THE DEPARTMENT CHAIR WILL •

1. be responsible for the clinically and administratively related activities within the department;
2. monitor the professional performance of department members and report to the Credentials and Medical Executive Committees as part of the reappointment process and at such other times as may be indicated;
3. be a member of the Medical Executive Committee and be responsible for the development and implementation of policies and procedures that guide and support the provision of services;
4. be responsible for monitoring, evaluating, and improving quality and appropriateness of patient care by members of his or her department;
5. develop a specific peer review plan for his or her department every two (2) years for approval by the Department and Medical Executive Committee (MEC), and otherwise lead and participate in peer review as set forth in the Bylaws and Peer Review and Performance Policy;
6. if determined appropriate by Department, establish and maintain a Supervisory Committee as described in the Bylaws.
7. be responsible within the department for the enforcement of the Medical Staff Bylaws, policies, rules and regulations;
8. be responsible for implementation within the department of actions taken by the Board and the Medical Executive Committee;
9. recommend criteria for clinical privileges within the department;
10. report to the Credentials and Medical Executive Committees concerning the appointment, reappointment and delineation of clinical privileges for all applicants seeking privileges in the department;
11. be responsible for the orientation, teaching, education and research programs in the department;
12. be responsible for the integration of the department into the primary functions of the organization. Be responsible for the coordination and integration of inter/intra departmental services;
13. cooperate and coordinate with the nursing service, the Quality and Safety Council (QSC), and other improvement teams requested by QSC, as necessary to insure that the activities of the department are consistent and coordinated with the various quality improvement groups;
14. assist the hospital management in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Medical Executive Committee, the Chief Executive Officer or the Board;
15. report to the chair of the Medical Executive Committee any situation involving questions of clinical competency, patient care and treatment, case management, professional ethics, infraction of hospital or Medical Staff Bylaws or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff;
16. perform all duties and responsibilities of a department chair set forth elsewhere in the Medical Staff Bylaws or Policies and Procedures;
17. assess and recommend to the relevant hospital authority, off-site sources for needed patient care services not provided by the department or the Hospital;
18. recommend regarding the sufficiency of number of qualified and competent individuals to provide care/clinical services;
19. make recommendation to the Hospital Administration and/or the Medical Executive Committee regarding the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services in the department;
20. report and recommend to Hospital management when necessary matters affecting patient care in the department, including personnel, space and other resources, supplies, special regulations, standing orders and techniques; and
21. establish clinical sections within the department as needed.

B. SUCCESSION OF DUTIES • All duties and responsibilities of the department chairs will be completed and fulfilled by the chair-elect in the absence of the chair and at such times when the department chair is otherwise unable to perform his or her duties and responsibilities. With the approval of the Medical Executive Committee, a department chair may designate another member of the department to serve on the Medical Executive Committee.

C. TERM OF OFFICE • Each department officer will serve a term of two (2) years commencing at the annual general Medical Staff meeting. (rev. 6/02)

D. ELECTION • Department officers will be elected by majority vote of the voting members of the department, present at the meeting in which the vote is held. The decision is subject to ratification by the Medical Executive Committee.

E. REMOVAL FROM OFFICE • Department officers may be removed from office by the Medical Executive Committee if any of the following occur:
1. The department officer ceases to be a member in good standing of the Active Medical Staff;
2. The department officer suffers a loss or significant limitation of clinical privileges, or if any other good cause exists;
3. The department officer fails to demonstrate to the satisfaction of the Medical Executive Committee or Board that the department officer is effectively carrying out the responsibilities of the position; and/or
4. The department initiates the process for removal of an officer by petition of twenty percent (20%) of the active Medical Staff members of the department. If a valid petition is presented to the President of the Medical Staff, he or she will forward the petition to the Medical Executive Committee at its next scheduled meeting. The Medical Executive Committee will approve a recall election, and the officer will be removed at such recall election if two-thirds (2/3) of the active Medical Staff members of a department vote in favor of the recall.
   If removal of the chair is required, the chair-elect will assume responsibilities and a special election will be held by the Department to elect a replacement chair-elect.

SECTION 3. FUNCTIONS OF DEPARTMENT CHAIR AND CHAIR ELECT

The department chair and chair-elect will carry out the responsibilities assigned to each of them, respectively, within the Organization Manual.

SECTION 4. ASSIGNMENT TO DEPARTMENT

The Medical Executive Committee will, after consideration of the recommendations of the chair of the appropriate department, recommend department assignments for all Medical Staff Members based on their qualifications. Each Medical Staff Member will be assigned to one primary department.
ARTICLE V
COMMITTEES

SECTION 1. DESIGNATION AND SUBSTITUTION

There will be a Medical Executive Committee and such other standing and special committees as established by the Medical Executive Committee. Where a Medical Staff matter only requires the participation of, rather than direct oversight by, the Medical Staff, it may be dealt with through Medical Staff representation on Hospital committees established to perform such functions.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

Composition • The Medical Executive Committee will consist of the following:
1. Officers of the Medical Staff;
2. Department chairs;
3. Chair of the Credentials Committee;
4. Trauma Medical Director (ex officio);
5. Chief Executive Officer or his/her designee (ex officio);
6. Vice President, Chief Medical Officer (ex officio);
7. Vice President & Chief Quality Officer (ex officio);
8. Chief Nursing Officer (ex officio);
9. Program Director of the Boise Family Medicine Residency Program (ex officio);
10. Immediate past president of the Medical Staff (ex officio); and
11. Other ex officio members may be appointed by the President.
12. APP Inpatient Medical Director or Advanced Practice Professional Council Chair may attend as a Non-Voting Member

A. DUTIES • The duties of the Medical Executive Committee will be to:
1. Evaluate and monitor the overall quality, efficiency and appropriateness of medical care rendered to patients and the clinical performance of all practitioners holding clinical privileges, including the organization of the quality assurance activities of the Medical Staff and the mechanism used to conduct, evaluate and revise such activities;
2. Represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;
3. Coordinate the activities and general policies of the various departments and committees, and in particular, to recommend to the Board mechanisms to assure the same level of quality patient care throughout the Hospital;
4. Receive and act upon Department and committee reports and recommendations, and to make recommendations, as appropriate, concerning them to the Chief Executive Officer and the Board;
5. Submit recommendations to the Board concerning policies and procedures created under these Bylaws and the mechanisms pertaining to these matters and other Medical Staff matters relating to appointments, reappointments, Medical Staff category, department assignments, clinical privileges, and corrective action;
6. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Medical Staff Members, including initiating investigations and
initiating and pursuing corrective action, when warranted;
7. Make recommendations to the Chief Executive Officer and the Board on Medical-Administrative and Hospital management matters and be a liaison between and among the Medical Staff, Chief Executive Officer and the Board;
8. Communicate with the Medical Staff concerning the licensure and accreditation status of the Hospital, including the JCAHO accreditation;
9. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs consistent with the Hospital’s mission and philosophy;
10. Make recommendations concerning the structure of the Medical Staff, including the creation of committees, the mechanism by which Medical Staff Membership may be terminated and the mechanisms for fair hearing procedures;
11. Consider all requests to waive any automatic suspensions of clinical privileges and to waive such suspensions;
12. Annually review and make recommendations to the Hospital and the contracting physicians or physician group on quality of care and quality of service issues, as well as other appropriate issues, related to all exclusive Hospital facilities and medical services; and
13. Ensure participation of the Medical Staff in performance improvement.

B. **MEETINGS** • The Medical Executive Committee will meet at least six (6) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions will be maintained.

C. **REMOVAL FROM COMMITTEE** • A Medical Staff Officer or Department Chair who is removed from his/her position in accordance with Article III, Section 7 and Article VI, Section 2. F. will automatically lose his/her membership on the MEC.

**SECTION 3. CREDENTIALS COMMITTEE**

The Credentials Committee has the responsibility of performing those functions set forth in the Organization Manual.

**SECTION 4. BYLAWS COMMITTEE**

The Bylaws Committee has the responsibility of performing those functions set forth in the Organization Manual.

**SECTION 5. ADDITIONAL COMMITTEES**

The Medical Executive Committee will establish such other additional committees as required to perform its functions and duties. Such committees will include, but are not limited to, an Institutional Review Board and Cancer Committee. The responsibilities for the functions of these committees are set forth in the Organization Manual.
ARTICLE VI
MEETINGS

SECTION 1. ANNUAL AND SPECIAL MEDICAL STAFF MEETINGS

A. ANNUAL MEETINGS • An annual meeting of the Medical Staff will be held during the first quarter of each calendar year. Written notice of the meeting will be sent to all Medical Staff members and conspicuously posted.

B. SPECIAL MEDICAL STAFF MEETINGS • The President may call a special meeting of the Medical Staff at any time. The President will call a special meeting within twenty (20) days after receipt of a written request signed by not less than fifteen percent (15%) of the Active Medical Staff, or upon a resolution by the Medical Executive Committee. Such request or resolution will state the purpose of the meeting. The President will designate the time and place of any special meeting. No business will be transacted at any special meeting, except that stated in the notice of such meeting.

SECTION 2. DEPARTMENT, COMMITTEE AND CLINICAL SECTION MEETINGS

A. REGULAR MEETINGS • Committees and clinical sections may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments will hold meetings as needed to carry out department business as specified in the Organization Manual.

B. SPECIAL MEETINGS • A special meeting of any committee, clinical section or department may be called by or at the request of the chair, or by the President or Medical Executive Committee.

SECTION 3. PROVISIONS COMMON TO ALL MEETINGS

A. QUORUM •
   1. Unless otherwise provided in these Bylaws, those Medical Staff Members present, eligible to vote and voting will constitute a quorum for any regular or special meeting of the Medical Staff or its committees or departments.
   2. Fifty percent (50%) of the voting members of the Medical Executive, Credentials and Bylaws committees will constitute a quorum.

B. NOTICE OF MEETINGS • Unless otherwise provided in these Bylaws, written notice stating the place, day, hour and purpose(s) of any meeting of the Medical Staff, department or committee will be delivered not less than five (5) days before the time of such meeting. If an action item on a meeting agenda pertains to a Medical Staff Member, the Member will be provided notice individually within five (5) days before the time of such meeting.

C. ATTENDANCE REQUIREMENTS •
   1. Members of the Medical Staff are encouraged to attend all meetings of the Medical Staff. However, meeting attendance will not be used in evaluating Medical Staff Members at the time of reappointment.
   2. Members of the Medical Executive, Bylaws, and Credentials Committees are expected to attend all of the meetings held.
D. **Robert’s Rules of Order** • When needed, the latest edition of *Robert’s Rules of Order* will prevail at all meetings of the general Medical Staff, Medical Executive Committee, and department and committee meetings, except that the chair of any meeting may vote.

E. **Action at Regular/Special Medical Staff Meetings** • Except as otherwise specified, the action of a majority of the Active Medical Staff Members present, eligible to vote and voting at a meeting at which a quorum is present is the action of the group. Action may be taken without a meeting by the Medical Staff, a department, or committee by presentation of the question to each Member eligible to vote, in person, or by mail, and their vote recorded. A vote on an issue will be binding so long as the question is voted on affirmatively by a majority of the eligible votes cast. Ballots may be numbered to ensure that there is only one ballot submitted per Medical Staff Member; however, the numbering will be randomized to protect the anonymity of the Medical Staff Member’s vote. Such recommendation will then be forwarded to the Medical Executive Committee.

F. **Rights of Ex Officio Members** • The Chief Executive Officer or his or her designees may attend any committee and Department meeting of the Medical Staff as an ex officio member. Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee will have all rights and prerogatives of regular members thereof, except that they will not vote or be counted in determining the existence of a quorum. In addition, ex officio members may be excused from the meeting at the request of the chair.

G. **Minutes** • Minutes of the Medical Executive Committee, Credentials Committee, Bylaws Committee and department meetings will be prepared and will include a record of the attendance of members and the vote taken on each matter. The minutes will be signed by the Chair and copies or summary reports submitted to the Medical Executive Committee or other designated committee. A permanent file of the minutes of each meeting will be maintained.
ARTICLE VII

SECTION 1. EXCLUSIVE SERVICES

A. EXCLUSIVITY POLICY • In recognition of the Hospital’s policy that certain Hospital facilities will be used on an exclusive basis and certain medical services will be provided on an exclusive basis in accordance with contracts between the Hospital and practitioners selected by the Hospital and the Board. Applications for appointment and clinical privileges relating to those Hospital facilities and services specified in Article VII, Section 1, Paragraph B will not be accepted for processing, except for applications by professionals who have been granted exclusive rights under a contract with the Hospital, and practitioners employed or engaged by the professionals holding such exclusive rights to perform services under a contract with the Hospital.

For each of these areas subject to the Hospital’s exclusivity policy, the physicians or group of physicians who are under contract to the Hospital assume exclusive responsibility for adequate medical staffing, continuous coverage, maintenance of standards, organization and operation of their respective areas by virtue of their contract. All practitioners rendering service are doing so under authority of the contract.

Physicians practicing in those areas subject to the exclusivity policy will be either themselves the contracting physicians, members of a contracting group, or physicians who are in association with, or under contract to, the contracting physicians or group. All such physicians must apply for, receive, and maintain Medical Staff Membership and privileges commensurate with their practice and responsibilities.

B. FACILITIES AND SERVICES TO THE EXCLUSIVITY POLICY • Hospital facilities and services subject to the foregoing exclusivity policy include medical oncology, pathology, radiology, anesthesiology, emergency room services at the Hospital’s main campus and Eagle Health Plaza locations, radiation oncology and trauma surgery at the Hospital’s main campus location. The Board reserves the right, from time to time, in its sole discretion, to make other Hospital facilities and services subject to the exclusivity policy and to enter into exclusive contractual arrangements with practitioners.

C. MEDICAL STAFF ASSISTANCE WITH AND RECOMMENDATIONS REGARDING CONTRACTING • If requested by Hospital Administration, or an existing contracting physician or group, the Medical Staff Officers who do not have a conflict due to direct involvement in an exclusive contract will make recommendations to facilitate and assist Hospital Administration and contracting Physicians/groups with contract negotiations and the resolution of contract issues.

The ultimate authority for all contracts relating to exclusive facilities and services rests with the Board of Trustees.

D. EFFECT OF CONTRACT EXPIRATION OR TERMINATION • The effect of expiration or termination of a contract between a practitioner and the Hospital on a practitioner’s staff status and clinical privileges will be governed by the terms of the practitioner’s contract with the Hospital. No action, recommendation or decision by the Hospital or the Board with regard to the expiration,
termination or failure to renew any such contract with a practitioner will be subject to or conditioned upon any proceedings or exercise of rights under these Bylaws. Practitioners exercising privileges subject to the exclusivity policy will, upon termination of the contract or relationship described above, automatically relinquish their privileges, notwithstanding any other provisions of these Medical Staff Bylaws to the contrary.

SECTION 2. COMPLIANCE WITH APPLICABLE LAWS

These Bylaws are intended to comply and be consistent with all applicable federal, state and local laws, rules and regulations and, including but not limited to those laws, rules and regulations pertaining to patient care, medical records, licensure of practitioners and hospitals, or peer review of practitioners, including, without limitation, the Health Care Quality Improvement Act of 1986 and its regulations. In the event of a conflict between any such laws, rules, or regulations and these Bylaws, the provisions of the applicable law, rule or regulation will control and will be followed.

SECTION 3. CONFIDENTIALITY

A. POLICY • Except as provided below, all written records of interviews, all reports, statements, minutes, memorandum, charts, and the contents thereof, and all physical materials relating to the processing of an initial application for appointment, corrective action procedures, hearing and appeal procedures and the proceedings of all medical staff committees, will be confidential and no disclosure of such information will be made outside the context of the proceedings provided for in these Bylaws. Nothing herein will prevent limited disclosure of information deemed confidential hereunder in the following circumstances:

1. The reporting, disclosure or notification of corrective action taken as required by State or Federal law or regulation;
2. Where the Medical Staff Member about whom the information pertains consents to the disclosure of such information and no privileged or confidential information regarding any other patient, physician or person will be disclosed thereby; or
3. Where any Medical Staff Member whose conduct, care, behavior, health, or standards of ethics or professional practice is the subject of review, investigation or corrective action as provided in these Bylaws, makes claim or brings suit on account of such investigation, review or corrective action, then, in defense thereof, confidentiality will be deemed waived by the making of such claim and the Hospital, Medical Staff Members and the Medical Staff and its committees will be entitled to resort to such otherwise protected information for the purpose of presenting proof of the facts surrounding the matter.

B. DISCLOSURE LIMITATIONS • Whenever information deemed confidential under this provision is permitted to be disclosed as provided above, the disclosure of such information will be made in an manner and by means designed, to the reasonable extent possible, to preserve the confidentiality of such materials and information.

SECTION 4. HISTORY AND PHYSICAL REQUIREMENTS

A. POLICY • An independent practitioner must perform the history & physical.

1. The privilege to perform and document a history & physical are fundamental rights of medical doctors and doctors of osteopathic medicine and therefore will be granted.
2. A history & physical performed by an allied health practitioner, specifically granted a scope of practice to perform a history & physical must be countersigned as outlined in the Allied Health Plan.

3. A history & physical performed by a resident or fellow is subject to the supervision guidelines outlined in the Medical Staff Policy & Plans.

4. A history & physical performed by a podiatrist or dentist, specifically granted privileges to perform a complete history & physical requires the mandatory use of the Hospital’s Pre-admission Testing Center.

5. Podiatrists and dentists who have not been granted privileges to conduct a complete history & physical must complete the portion of the history & physical related to podiatry or dentistry, respectively. The remaining required components of the history & physical, as outlined in Section 3 of this policy, must be completed by an Active or Courtesy physician member of the SARMC Medical Staff.

6. When the history & physical is not present before an operation or any potentially hazardous diagnostic procedure, the history and physical will be completed immediately prior to beginning the operation or procedure. The history and physical will be directly entered into the electronic medical record system and immediately available for other caregivers.

7. It is recognized that the prenatal patient is a special situation in that, in and of itself, the prenatal course is a planned, systematic updating of the history & physical performed at the first visit and throughout the pregnancy. As such, the entire prenatal record can be utilized as the history & physical, provided it is updated to reflect the patient’s condition upon admission.

**B. INPATIENTS**

Patients admitted to Saint Alphonsus Regional Medical Center require a complete history and physical examination within twenty-four (24) hours of admission or prior to an operation or potentially hazardous procedure, whichever occurs first. A complete history and physical includes the chief complaint; details of the present illness; allergies; current medications; relevant past, social, and family histories; an inventory by body system; the results of diagnostic tests; a full physical examination; diagnosis/impression; and a plan of care.

**C. AMBULATORY PATIENTS**

1. Ambulatory patients receiving general, spinal or major regional anesthesia, moderate or deep sedation, require an appropriate history and physical examination to be present in the patient's medical record. When the history and physical is not present or available it will be immediately completed prior to beginning the operation or procedure. The history and physical will be directly entered into the electronic medical record system and immediately available for other caregivers. An appropriate history and physical includes, at a minimum, details of the present illness, allergies, current medications, past history, mental status, physical examination relevant to the present illness, cardiopulmonary examination, a preoperative diagnosis, and a treatment plan.

2. Ambulatory patients, who will undergo a therapeutic or diagnostic procedure with local anesthesia or without anesthesia or sedation that is likely to result in a significant physiological effect (such as emergency surgery or hospitalization) or patients who do not undergo a procedure, anesthesia, or sedation but remain in the hospital for observation, require a relevant history and physical to be present in the patient's medical record. When the history is not present or available it will be completed immediately prior to beginning the procedure or observation period. The history and physical will be
directly entered into the electronic medical record system and immediately available for other caregivers. A relevant history and physical includes, at a minimum, indications for the procedure or observation, diagnosis/impression, mental status, a treatment plan and a complete nursing assessment.

D. **EMERGENCIES** • In an emergency, when there is no time to record the history and physical examination, a note documenting the preoperative diagnosis is recorded prior to the procedure. The history and physical must then be documented within twenty-four (24) hours. Following the procedure, the attending practitioner will state in writing that delaying the procedure to document the history and physical would have been detrimental to the patient.

E. **THIRTY (30) DAY RULE** • If a history and a physical examination have been performed within thirty (30) days before admission, a legible copy of this report may be used in the patient's medical record. If a history and physical has been completed more than 30 days prior to admission, a completely new history and physical must be performed and documented.

F. **UPDATE TO PATIENT’S CONDITION** • If the history and physical was performed within thirty (30) days prior to admission and/or an operation or potentially hazardous diagnostic procedure then the patient will be reevaluated by a Practitioner with privileges to perform a history and physical examination. An entry is required to chart the changes or to indicate no change at the time of admission or immediately prior to an operation or potentially hazardous diagnostic procedure.
   1. The update note must document an examination for any changes in the patient's condition since the time that the patient's H&P was performed that might be significant for the planned course of treatment.
   2. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed.
   3. In the situation where the patient is going to surgery within the first 24 hours of admission, the preanesthesia assessment may serve as the update to the patient’s condition.
   4. In the situation where the patient is going to surgery after 24 hours of admission, the daily progress note may serve as the update to the patient’s condition.
   5. If an Allied Health Provider (AHP), with approved scope of practice, provides the update to the history and physical, the update will be countersigned immediately prior to beginning the operation or procedure by the supervising or performing physician.

G. **DENTAL PATIENTS** • For dental patients undergoing a procedure in the operating room, the preoperative assessment performed by the anesthesiologist will satisfy the update note requirement. The dentist must update that portion of the history and physical related to dentistry.

H. **HISTORY AND PHYSICAL CONDUCTED IN PHYSICIAN’S OFFICE** •
   1. Copies of histories and physicals performed by a member of the medical staff in their office may be used in lieu of dictating a new one provided it meets the requirements for legibility, timeliness and content as described above.
2. A copy of a letter from a member of the medical staff to a referring physician is acceptable documentation of a history and physical provided it meets the requirements for legibility, timeliness and content as described above.

<table>
<thead>
<tr>
<th>PATIENT CATEGORY</th>
<th>SCOPE OF HISTORY AND PHYSICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Complete</td>
</tr>
<tr>
<td>Ambulatory patients receiving general, spinal or major regional anesthesia, conscious sedation or deep sedation</td>
<td>Appropriate</td>
</tr>
<tr>
<td>Ambulatory patients, who will undergo a therapeutic or diagnostic procedure with local anesthesia or without anesthesia or sedation that is likely to result in a significant physiological effect (such as emergency surgery or hospitalization)</td>
<td>Relevant</td>
</tr>
<tr>
<td>Patients who do not undergo a procedure, anesthesia, or sedation but remain in the hospital for observation</td>
<td>Relevant</td>
</tr>
</tbody>
</table>

I. **COMPLETE HISTORY AND PHYSICAL** • A complete history and physical will contain the following:

- chief complaint
- details of the present illness
- allergies
- current medications
- relevant past
- social, and family histories
- mental status
- inventory by body system
- results of diagnostic tests
- pertinent physical examination
- diagnosis/impression
- plan of care

J. **APPROPRIATE HISTORY AND PHYSICAL** • An appropriate history and physical will contain the following:

- details of the present illness
- current medications
- mental status
- preoperative diagnosis
- physical examination relevant to the present illness
- allergies
- past history
- cardiopulmonary examination
- plan of care

K. **RELEVANT HISTORY AND PHYSICAL** • A relevant history and physical will contain:

- diagnosis/impression
- complete nursing assessment
- plan of care
- indications for the procedure or observation
SECTION 5. CONFLICT OF INTEREST

POLICY • For purposes of this policy, a conflict of interest arises when there is a divergence between a Medical Staff member's private interests and his/her professional obligations to the Hospital, other Medical Staff, patients and employees such that an independent observer may reasonably question whether the Medical Staff member's professional actions or decisions are determined by considerations of personal gain, financial or otherwise. The existence of a conflict of interest is based upon a given situation, and not the character or actions of a specific Medical Staff member. Medical Staff members have a duty to report when any actual or potential conflict of interest is suspected.
APPLICATION PROCESS FOR INITIAL APPOINTMENT AND DELINEATION OF CLINICAL PRIVILEGES

SECTION 1. POLICY

It is the policy of Saint Alphonsus Regional Medical Center Medical Staff ("Medical Staff") to process applications for Medical Staff membership and/or for clinical privileges only for those individuals who meet the Basic Qualifications for Membership described in Article I, Section 3 of the Medical Staff Bylaws, and the requirements of the Department in which the Practitioner is seeking clinical privileges. Individuals in administrative positions are subject to the same procedures as all other applicants.

SECTION 2. REQUEST FOR APPLICATION

A. PROCESS INITIATION • All requests for application for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Office of Medical Affairs.

B. Upon request for an application, the Office of Medical Affairs will:
   1. Make available the Medical Staff Bylaws;
   2. Make available the Basic Qualifications for Membership as outlined in the Medical Staff Bylaws;
   3. Make available the requirements, rules and regulations of the Department in which the individual is seeking clinical privileges;
   4. Provide access to clinical privilege request form(s);
   5. Verify a current email address, date of birth and contact information;
   6. Determine if the individual meets the Basic Qualifications for Medical Staff Membership as outlined in the Medical Staff Bylaws.
      a. Individuals who do not meet the Basic Qualifications based on the information they have provided will not begin the application process.
      b. Individuals who submit an application which is deemed incomplete will not be entitled to any procedural rights under the Medical Staff Bylaws Fair Hearing Plan.

SECTION 3. APPLICATION PROCESS

A. CONTENTS OF THE APPLICATION • Each application for appointment to the Medical Staff will contain the following:
   1. Completed application form(s) and associated documents;
   2. non-refundable application fee;
   3. any additional information, clarifications and/or documentation requested;
   4. complete updated information requested on the original application or subsequent privilege request form(s).
B. **PENDING ITEMS** • In the event an application is reviewed and it is determined that all of the Basic Qualifications for Membership are met except the Idaho State License, Professional Liability Insurance, DEA Certificate or Idaho State Board of Pharmacy Certificate are pending, an application may be given. The applicant will be advised that their application will not be transmitted to the Credentials Committee, nor will they be eligible for temporary privileges, until the pending items are received. Any application being held for one of the aforementioned pending items will not be processed, if the pending items fail to document fulfillment of the basic requirements for membership or are not received within 120 days of receipt of the application.

C. **APPLICANT’S SIGNATURE** • By signing, or electronically signing/submitting the application, the Applicant agrees to provide to the Office of Medical Affairs all of the aforementioned documents and fees. Further, by signing, or electronically signing and submitting the application form(s) the Applicant attests to meeting all of the Basic Qualifications for Membership as outlined in the Medical Staff Bylaws and/or the requirements for clinical privileges in the Department for which he or she is applying.

1. If an Applicant fails to meet any of the Basic Qualifications for Membership, he or she will be deemed ineligible for consideration of appointment and the application will be deemed incomplete and will be rejected.

2. Incomplete applications will not be transmitted to the Credentials Committee.

3. Applicant who submits an application which is deemed incomplete will not be entitled to any procedural rights under the Medical Staff Bylaws Fair Hearing Plan.

D. **RESIDENTS & FELLOWS** • Practitioners currently in a residency or fellowship program will be verified to the fullest extent practicable but may not be transmitted to the Credentials Committee until such time that all required primary source verification has been completed in accordance with Chapter V of the Medical Staff Policy and Plans. In the event that a resident or fellow fails to provide adequate documentation, the application will be deemed invalid and the applicant ineligible.

E. **PROCESSING THE APPLICATION** •

1. Applicant’s Burden. The Applicant will have the burden of producing complete and adequate information for a proper evaluation of his or her licensure, relevant training, experience, current clinical competence, and ability to safely and competently exercise the Clinical Privileges requested with or without accommodation, and of resolving any doubts about these or any of the other Basic Qualifications for Membership specified in the Medical Staff Bylaws.

2. Processing and Solicitation of Information. When the application is returned, it will be reviewed to be certain all questions are answered fully, including the complete addresses of all references. If questions are left blank, the application will be returned and the Applicant informed that processing will not begin until the answers are supplied. The Office of Medical Affairs will also solicit and receive information concerning the Applicant from practitioners and peers who have clinical privileges at the Hospital, if any. The name of each Applicant will be posted in the Hospital so that each medical staff member may have an opportunity to submit to the chair of the Credentials Committee, in writing, information bearing on the Applicant. Alternatively, any current medical staff member will be entitled to appear in person before the Credentials Committee to discuss any concerns he or she may have about
the Applicant.

3. Verification of Qualifications Information. Whenever feasible, verification of information will begin within five (5) working days of receipt of an Application containing all requested information. The Office of Medical Affairs will, in a timely fashion, seek to collect or verify the information submitted. The Office of Medical Affairs will advise the Applicant of any failure of others to respond to such verification efforts and the Applicant will have the obligation of providing responses.

4. Completed Application. An application for medical staff membership and/or clinical privileges, initial or renewal, is not complete until it includes any information the Applicant has been called upon by a department chair, chair of the Credentials Committee, the CEO, or designee, to provide, and that information is verified. If all responses to requests for information are not received within one hundred twenty (120) days after being requested, the application will be deemed rejected, and such action will not be deemed to be adverse to the Applicant. The Applicant will not be entitled to exercise the procedural rights as defined in the Bylaws or in the Fair Hearing Plan. When collection and verification of information is complete, the Office of Medical Affairs will transmit the application and all related materials to the chair of the department in which the Applicant seeks clinical privileges.

SECTION 4. CREDENTIALING PROCEDURE

It is the Hospital’s policy to consider approval of an application only after the Office of Medical Affairs has obtained a completed application. It is the intent of this policy to expedite Applications that meet pre-defined, Board-approved criteria as set forth below:

A. Verification Procedures • The current licensure, relevant training or experience and current competence of each applicant must be verified, preferably from the primary source (or equivalent source, such as the AMA profile). For all applicants, the following will be verified:
   1. State licensure;
   2. Medical school, internship/residency (if the applicant has recently graduated, a photo of the applicant will be included to verify the applicant’s identity), and fellowship (if applicable). In this circumstance, "fellowship" refers to an academic fellowship in the applicant's specialty which applies toward board certification or certificate of additional qualification; all other experiences, including postdoctoral fellowships, will be considered work experience
   3. Board certification;
   4. Hospital affiliations for the past 10 years;
   5. Two peer references, preferably from the same specialty;
   6. At a minimum, a copy of current professional liability certificate evidencing coverage within the required limits, will be provided;
   7. Narcotics Registration Certificate (Federal and State);
   8. National Practitioner Data Bank report;
   9. Criminal Background Check;
   10. Query of the Office of Inspector General (OIG) system for Medicare and Medicaid sanctions, including both current and pending investigations;
   11. Voluntary or involuntary limitation, reduction, suspension or loss of clinical privileges at another hospital;
   12. Voluntary or involuntary cancellation of professional liability insurance, or license/Drug Enforcement Administration; and
   13. All other applicable basic requirements for membership, as outlined in the Medical Staff Bylaws, Article I, Section 3.
B. **APPLICATION CATEGORIES** • All Applications will be reviewed and processed as Category One Fast Track or Category Two Regular Track. Each application will be processed under the same standards whether Category One or Category Two.

1. Category One (Fast-track) Applications. An Application which meets all of the following criteria:
   a. there are no negative or questionable recommendations or any other data received from any source which are believed to be of significance to the Applicant's appointment;
   b. the Applicant’s history shows an ability to work cooperatively, and relate to others in a harmonious, collegial manner;
   c. there are no material discrepancies in information received from the Applicant or references;
   d. the Applicant has submitted a reasonable request for clinical privileges, consistent with his or her specialty, based on his or her licensure, experience, training and current clinical competence;
   e. there are no gaps in time for which the Applicant has not accounted;
   f. the Applicant has not changed practice locations more than three (3) times in the past ten (10) years or has not held more than five (5) medical licenses across the United States without reasonable explanation;
   g. the Applicant has not been involved in three (3) or more malpractice claims in the past ten (10) years or any settlements or judgments in the past five (5) years;
   h. there are no pending or previous disciplinary actions by a state licensing board, a state or federal regulatory agency, other health care organizations;
   i. there are no National Practitioner Data Bank entries other than a malpractice history which meets the requirements of subsection g above;
   j. there are no sanctions or investigations present from the Office of Inspector General;
   k. the Applicant has had no voluntary or involuntary limitation, reduction, suspension or loss of clinical privileges at another hospital;
   l. the Applicant has had no voluntary or involuntary cancellation of professional liability insurance(s), or license/Drug Enforcement Administration certificates;
   m. the Applicant completed a normal education/training sequence; and
   n. all requested information has been returned promptly.

2. Category Two (Regular Track). Applications which do not satisfy all the requirements for Category One.

C. **DEPARTMENT CHAIR** • The appropriate department chair will:

1. review the application and transmit to the Credentials Committee a written report providing a favorable or unfavorable recommendation for medical staff status and/or clinical privileges to be granted, including any special conditions regarding the appointment or granting of clinical privileges;
2. prior to preparing and transmitting the written report, the chair, at his or her discretion, may require that the Applicant be interviewed by other members of the medical staff, or may request additional information;
3. may recommend that the Medical Executive Committee defer action on the application. The reason for each recommendation and any proposed special conditions will be concisely stated in the report;
4. to the extent he or she deems appropriate, may delegate to other members of his or her
department, the duties and responsibilities set forth in this section; and
5. following review and recommendation by the department chair, the application will be forwarded to the Credentials Committee.

D. CREDENTIALS COMMITTEE •
1. Category One Applications. The chair of the Credentials Committee, or designee, will review the application, the related documentation compiled, the department chair’s report and recommendations, and other information available that may be relevant. The Credentials Committee chair has the ultimate authority to determine if the Applicant is Category One or Category Two. If the Credentials Committee chair recommends the application, then acting on behalf of the Credentials Committee, the Credentials Committee chair will then transmit a report to a representative of the Medical Executive Committee (President or President-Elect of the Medical Staff). The report will contain concisely stated recommendations concerning medical staff status, department assignment, clinical privileges to be granted and any special conditions to be attached to an appointment or grant of clinical privileges. The Credentials Committee member may also defer action on the application, in which case the application will be considered a Category Two.

2. Category Two Applications. The full Credentials Committee will review the application at the next regularly scheduled meeting for review of all of the information specified in Chapter I, Section 4B1 above. The Credentials Committee may conduct, if it so desires in its sole discretion, a personal interview with the Applicant or may request additional information. The Credentials Committee will then transmit a report to the full Medical Executive Committee, which will contain concisely stated recommendations as to medical staff status, department assignment, clinical privileges to be granted and any special conditions to be attached to the appointment or grant of clinical privileges. The Credentials Committee may also defer action on the application. The reason for each recommendation will be concisely stated. Any minority views will also be reduced to writing, supported by concise statements of reasons and transmitted with the majority report. The Credentials Committee also has the authority to change the application from Category Two to Category One.

3. Deferral. Deferral by the Credentials Committee of the application for further consideration should be followed within thirty (30) days by subsequent recommendations as to approval or denial of, or any special limitations to, medical staff status, and clinical privileges.

E. TRAINING REQUIREMENT • Confirmation must be received by the Office of Medical Affairs that the applicant has successfully completed appropriate SARMC electronic health record training prior to admitting or managing patients.

F. MEDICAL EXECUTIVE COMMITTEE •
1. Category One Applications. The President of the Medical Staff or another officer of the Medical Staff in his or her absence, as a representative of the Medical Executive Committee will review the application, the related documentation compiled, each department chair’s report and recommendations, and other information available to it that may be relevant. The Medical Executive Committee representative has the prerogative of changing the designation to Category Two. If the Medical Executive Committee representative recommends the application, then acting on behalf of the Medical Executive Committee, he or she will provide a report to a representative of the Board. The report will contain recommendations as to staff status, department assignment, clinical privileges to be granted and any special conditions to
be attached to the appointment. The reason for each recommendation will be concisely stated.

2. Category Two Applications. At the next regularly scheduled meeting of the Medical Executive Committee, it will review the information specified in Chapter I, Section 4C and D above. The Medical Executive Committee may conduct, if it so desires in its sole discretion, a personal interview with the Applicant or may request additional information. The Medical Executive Committee will then transmit a report to the Board, which will contain concisely stated recommendations as to medical staff status, department assignment, clinical privileges to be granted and any special conditions to be attached to the appointment or clinical privileges granted. The Medical Executive Committee may defer action on the application. Any minority views will also be reduced to writing, supported by concise statements of reasons and transmitted with the majority report.

3. Initial Recommendation to Deny Application. In the event the Medical Executive Committee recommends denial of appointment or clinical privileges, the recommendation will be treated as an initial recommendation. The CEO will notify the Applicant in writing of the negative initial recommendation and of the Applicant’s right to request reconsideration of that recommendation by an ad hoc review committee. The Applicant will have ten (10) days following the date of mailing of the written notice of the initial adverse recommendation from the CEO in which to submit his or her written request for reconsideration. If the Applicant does not respond within ten (10) days the Applicant will be deemed to have accepted the initial adverse recommendation of the Medical Executive Committee, and it will be treated as the final Medical Executive Committee recommendation and transmitted to the Board.

4. Reconsideration Panel. If the Applicant timely requests reconsideration in writing, the Medical Executive Committee will appoint a Reconsideration Panel consisting of at least three (3) members of the active Medical Staff, designate its chair, and establish its charge at its next regular meeting. The Reconsideration Panel will review the recommendations and all prior recommendations and supporting materials; and may, at its election, conduct its own investigation and meet with the Applicant (and other individuals with information). The Reconsideration Panel will then formulate and transmit its recommendation to the Medical Executive Committee, prior to the next Medical Executive Committee meeting, which will be no later than sixty (60) days following the meeting at which the initial adverse recommendation was voted upon.

5. Final Recommendation following Reconsideration Panel. Within sixty (60) days of the meeting at which the initial adverse recommendation was voted upon, the Medical Executive Committee will consider the report and recommendations of the Reconsideration Panel and vote to affirm, modify, or disaffirm its initial recommendation. The recommendation of the Medical Executive Committee at this stage will constitute a final recommendation that will be transmitted to the CEO and by the CEO to the Applicant.

6. Withdrawal. An Applicant may at any time withdraw his or her application from further consideration, and the Application will not be transmitted to the Board for action. An application which is withdrawn will not be deemed rejected or denied provided that it is withdrawn prior to the conduct of a Fair Hearing.

G. EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

1. Deferral. Action by the Medical Executive Committee to defer the application for further consideration must be followed up within thirty (30) days with a subsequent favorable or adverse recommendation.

2. Favorable Recommendation. When the recommendation of the Medical Executive Committee is favorable to the Applicant, the CEO will promptly forward it, together with
the application and all related documentation, to the Board.

3. Adverse Recommendation. When the recommendation (including those made after deferral) of the Medical Executive Committee is adverse to the Applicant, the CEO will so inform the Applicant.

4. Procedural Rights. Only Applicants who have requested reconsideration of an adverse recommendation will be entitled to the procedural rights as provided in the Fair Hearing Plan. For the purposes of this section, an "adverse recommendation" by the Medical Executive Committee is as defined in the Fair Hearing Plan, “Grounds for a Hearing.”

H. BOARD ACTION

1. Category One. If the Application is designated Category One, it is presented by the appropriate Medical Executive Committee representative to a delegated member of the Board and the CEO or his or her designee, for review and recommendation. The delegated member of the Board and the CEO or designee has the prerogative of changing the designation to Category Two. If forwarded as a Category One, the delegated member and CEO or designee acts on behalf of the Board in approving the membership and/or granting clinical privileges. The Office of Medical Affairs will prepare a report quarterly for the Board, identifying those Practitioners who were appointed and granted clinical privileges as Category One Applicants.

2. Category Two. If the Application is designated Category Two, the Board may either adopt or reject a favorable recommendation of the Medical Executive Committee, in whole or in part; or it may refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral and setting a reasonable time limit within which a subsequent Medical Executive Committee recommendation will be made. If the Board’s action is adverse to the Applicant, the CEO will so inform the Applicant. The Applicant will be entitled to the procedural rights as provided in the Fair Hearing Plan.

3. Medical Executive Committee Subsequent Recommendation. If the Board does not receive a subsequent Medical Executive Committee recommendation within the time period specified in this policy, it may, after five (5) days notice to the Medical Executive Committee, take action on its own initiative. If the Board’s action is favorable, it will become effective on the date the Board renders its decision. If such action is adverse, as defined in the Fair Hearing Plan, “Grounds for a Hearing,” the CEO will so inform the Applicant. The Applicant will be entitled to the procedural rights as provided in the Fair Hearing Plan.

4. After Procedural Rights. In the case of an adverse Medical Executive Committee recommendation or an adverse Board decision, the Board will take final action in the matter only after the Applicant has exhausted or has waived his or her procedural rights as provided in the Fair Hearing Plan. Action thus taken will be the final decision of the Board. However, the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back will state the reasons therefore and will set a reasonable time limit within which a subsequent recommendation to the Board will be made. After receipt of such subsequent recommendation, the Board will make a final decision.

I. NOTICE OF FINAL DECISION • A decision and notice to appoint will include:

1. the Medical Staff status to which the Applicant is appointed;
2. the Department to which he or she is assigned;
3. the Clinical Privileges he or she may exercise; and
4. any special conditions attached to the appointment or exercise of Clinical Privileges.

J. REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION • An Applicant who has received a final adverse decision regarding appointment will not be eligible to reapply for a period of two (2)
years. Any such reapplication will be processed as an initial Application.

K. **PROVISIONAL PERIOD** • All initial appointments to the Medical Staff, will be provisional until sufficient performance data is available to evaluate clinical competence. During the provisional period the individual's competence to exercise the clinical privileges granted and general conduct in the Hospital will be evaluated. This evaluation will be reviewed by the chair of his or her department and include Focused Professional Practice Evaluation (FPPE) criteria for each privilege requested. Continued appointment after the provisional period will be conditioned upon an evaluation of the FPPE criteria. Additionally, all Provisional practitioners will be required to attend Physician Orientation. Residents, Affiliate Staff Members, Fellows, Locum Tenens Staff and Telemedicine Courtesy Staff are exempted from this provision.

L. **FOCUSED PROFESSIONAL PRACTICE EVALUATION** • The department chair will assign Focused Professional Practice Evaluation criteria at the time of initial appointment and/or request for new privileges. FPPE will include and evaluation of the content and quality of History and Physicals, direct oversight, peer evaluation, or retrospective review of cases or other criteria determined by the department chair to ensure clinical competence within the facility.

M. **INTENSIFIED PROVISIONAL PERIOD** • Practitioners that cannot provide adequate documentation of current clinical competence for all or any part of the privileges requested (i.e. a specialist that has been practicing general medicine in the military or a Practitioner that has been providing primarily outpatient care and/or extended periods of absence due to maternity/paternity) may be required to enter an intensified provisional period. During an intensified provisional period, the Practitioner will not be granted the delineated clinical privileges for which current clinical competence has not been documented. Applicants in this category must identify an active member of the medical staff who currently possesses the requested clinical privilege to act as a proctor. The Applicant will be authorized to exercise a scope of practice subject to proctor supervision. The Practitioner's proctor supervision requirements may not be more restrictive than those outlined for Residents in Chapter V of the Medical Staff Policy & Plans. The burden of identifying appropriate intensified provisional period proctors rests solely on the Applicant. The Applicant must submit, in writing, a detailed plan for proctorship, including the names of the proctors. The detailed plan will accompany the application and must be approved by the department chair and Credentials Committee. Successful completion of the intensified provisional period will be considered independent of the provisional period outlined in paragraph J, above.

**SECTION 5. TIME PERIODS FOR PROCESSING**

A. **COMMITTEE LIMITS** • All individuals and committees required by the Bylaws and this Credentials Manual to consider and act upon applications for Medical Staff appointments will do so in a timely manner within the time limits specified in any applicable law, and, except for good cause, within the time periods specified in this Article.

B. **TRANSMITTAL LIMITS** • If an application was completed timely as specified in Chapter I, Section 3B above, under the direction of the CEO, the Office of Medical
Affairs will transmit an application to the Medical Staff upon completing information collection and verification tasks, but in any event within one hundred and twenty (120) days after receiving the application.

C. **EXCEPTIONS** • Except for good cause, the department chairs, Credentials Committee and Medical Executive Committee will review and make recommendations concerning the application in such a manner that the Medical Executive Committee is able to make its initial recommendation to the Board within one hundred twenty (120) days from the date the complete application is transmitted by the CEO.

D. **BOARD LIMITS** • The Board (or its applicable committee) will then take action on the application at its next regular meeting following final recommendation from the Medical Executive Committee.
ARTICLE IX
REAPPOINTMENT PROCESS

SECTION 1. REAPPOINTMENT FORM

The Office of Medical Affairs will, at least one hundred fifty (150) days prior to the expiration date of the present Medical Staff appointment of each Practitioner, provide the Practitioner with a form for use in considering reappointment (“Reappointment Form”).

Each Practitioner who desires reappointment will, within thirty (30) days of the date of mailing of the Reappointment Form, mail or deliver his or her Reappointment Form to the Office of Medical Affairs. Failure to return the Reappointment Form in a timely manner or information required in the reappointment packet within the timeframe specified by the Credentials Committee will be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of Medical Staff status together with all Clinical Privileges at the expiration of such Practitioner's current term of appointment; provided, however, that no automatic termination will be effective unless the Medical Staff Member has been provided written notice of this failure to provide the necessary information. Such automatic termination will not be deemed to be an “adverse” action to the Applicant as defined in the Bylaws and Fair Hearing Plan.

SECTION 2. CONTENT OF REAPPOINTMENT FORM

The Reappointment Form will be on the prescribed form and the reappointment Applicant will attest to the information contained in the initial Application form, or provide updated current information if required. The Reappointment Form will contain any request for modification of Medical Staff status or Clinical Privileges which the reappointment Applicant may desire to make.

SECTION 3. VERIFICATION OF INFORMATION

The reappointment Applicant will deliver a completed Reappointment Form to the Office of Medical Affairs. The Office of Medical Affairs will, in a timely fashion, seek to collect or verify the information requested concerning the Applicant.

SECTION 4. REAPPOINTMENT DURATION

A. MAXIMUM DURATION • As required by the Joint Commission on Accreditation of Healthcare Organization, MS.5.11, no appointment or reappointment may exceed two years.

B. RECOMMENDATION FOR LESS THAN TWO-YEAR REAPPOINTMENT • Recommendations for a reappointment period of less than two-years may be made by the Department Chair, Credentials Committee, Medical Executive Committee and/or the Quality Care & Professional Practices Committee of the Board.

A reappointment recommendation of less than two years is not an adverse action as
defined in the Medical Staff Corrective Action Section of these Bylaws and as such does not constitute grounds for an appeal. Additionally, reappointment recommendations of less than two years are not reportable to the National Practitioner Data Bank.

C. **GROUNDS FOR REAPPOINTMENT RECOMMENDATION OF LESS THAN TWO YEARS** • The following circumstances may warrant a reappointment recommendation of less than two years:

1. when there is insufficient information to recommend corrective action, but sufficient information to warrant further investigation;
2. when there is a lack of confidence that the practitioner will fulfill his/her responsibilities because of information or documentation that the practitioner may not be currently fulfilling his/her responsibilities, including behavioral issues;
3. failure to complete education and/or training requirements mandated by the Medical Executive Committee and approved by the Board (i.e. Continuing Education and Disruptive Physician/Sexual Harassment);
4. failure to provide information, in sufficient detail, as required in the Reappointment Form;
5. in the case of the criminal background check release form, failure to sign will result in a six-month reappointment followed by automatic relinquishment of privileges if not completed in that timeframe; (Added 4/07)
6. for any reason that the Medical Executive Committee or the Board requires additional information; or
7. for any reason by the Board.

D. **REAPPOINTMENT EXTENSIONS** • In the event that a practitioner is reappointed for less than two years the reappointment may be extended to a maximum of 24 months as outlined below:

1. In cases of failure to complete a requirement (CME, Specified Training Classes, etc), the practitioner will be automatically processed for an extension upon completion of the requirement; or
2. In cases where additional information is requested by the Department Chair, Credentials Committee, Medical Executive Committee, Quality Care & Professional Practices Committee or the Board of Trustees, an extension to a maximum of 24 months will be processed at the time the information is provided.

E. **LOW VOLUME PRACTITIONERS** • Upon renewal of clinical privileges, when insufficient practitioner-specific data are available, the practitioner must have met the minimum requirements set forth in Article II section 1, 2 and 4 or may be processed as Affiliate or Affiliate Consulting provider due to no activity in the hospital. The exception may be that the Medical Executive Committee will determine if such provider may continue with clinical privileges by utilizing peer-references and data from the primary practice facility may be evaluated, although information from another facility is considered supplemental and cannot be used in lieu of facility specific data. A continuation of the Provisional Period, if applicable, and Focused Professional Practice Evaluation (FPPE) may occur until clinical competence can adequately be evaluated. If practitioner is approved to maintain privileges due to the need of such specialty.

F. **REAPPOINTMENT APPLICATIONS ARE NOT REQUIRED WHEN PROCESSING REAPPOINTMENT EXTENSIONS** • In the event that the practitioner does not comply with the requirements outlined in the reappointment letter from the Board within the time frame allotted,
the practitioner will be automatically processed for a voluntary relinquishment of privileges and membership. Such relinquishment will not constitute grounds for a Fair Hearing as outlined in the Medical Staff Policy and Plans.

SECTION 5. DEPARTMENT ACTION

The appropriate Department chair will review the Reappointment Form and all relevant information, including Peer Review data, available on each reappointment and will transmit to the Credentials Committee his or her report and recommendation that the appointment be either renewed, renewed with modified Medical Staff status and/or Clinical Privileges, renewed with special conditions, or terminated. A Department chair may also recommend deferral of action for up to thirty (30) days when such deferral does not delay the reappointment process to cause the current appointment/reappointment beyond 24 months. If it appears that the current appointment/reappointment will exceed 24 months a reappointment recommendation of less than 24 months, as outlined in Section 3 of this Article, will be forwarded to the Credentials Committee. (Rev. 6/03)

SECTION 6. CREDENTIALS COMMITTEE ACTION

The Credentials Committee will review each Reappointment Form and all relevant information available on each reappointment Applicant, including the recommendation of each Department in which the Applicant has requested Clinical Privileges. The Credentials Committee will transmit to the Medical Executive Committee its report and recommendation that appointment be either renewed, renewed with modified Medical Staff status and/or Clinical Privileges, renewed with special conditions, or terminated. The Credentials Committee may also recommend that the Medical Executive Committee defer action for up to thirty (30) days when such deferral does not delay the reappointment process to cause the current appointment/reappointment beyond 24 months. If it appears that the current appointment/reappointment will exceed 24 months a reappointment recommendation of less than 24 months, as outlined in Section 3 of this policy, will be forwarded to the Medical Executive Committee. Any minority views will also be reduced to writing and transmitted with the majority report.

SECTION 7. MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee will review each Reappointment Form and all other related and relevant information available concerning each reappointment and will forward to the CEO for transmittal to the Board its report and recommendation that appointment be either renewed, renewed with modified Medical Staff status and/or Clinical Privileges, renewed with special conditions, or terminated. The Medical Executive Committee may also defer action for up to thirty (30) days when such deferral does not delay the reappointment process to cause the current appointment/reappointment beyond 24 months. If it appears that the current appointment/reappointment will exceed 24 months a reappointment recommendation of less than 24 months, as outlined in Section 3 of this policy, will be forwarded to the Quality Care & Professional Practices Committee of the Board. Any minority views will also be reduced to writing and transmitted with the majority report.

SECTION 8. FINAL PROCESSING AND BOARD ACTION

Thereafter, the procedure provided in this Article for appointment, will be followed. For purposes of reappointment, the terms "Applicant" and "appointment" as used in those sections will be read, respectively, as "reappointment applicant" and "reappointment."
ARTICLE X  TEMPORARY PRIVILEGES

SECTION 1. CONDITIONS FOR TEMPORARY CLINICAL PRIVILEGES

Only in exceptional circumstances, after receipt of a completed and verified application, temporary privileges may be granted, for a time period not to exceed one hundred twenty (120) days, on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice. Temporary privileges will only be granted to practitioners who are licensed in Idaho, or otherwise authorized under Idaho law, to exercise temporary privileges. Examples include, but are not limited to:

A. ILLNESS, LEAVE OR VACATION • A situation where a physician becomes ill, takes a leave of absence or a vacation and another physician would need to cover his or her practice until he or she returns, such as a locum tenens physician.

B. IMPORTANT PATIENT CARE NEED • A specific physician has the necessary skills to provide care to a patient that a physician currently privileged does not possess, such as to supervise a clinical procedure.

C. APPLICATION UNDER REVIEW • When an applicant with a complete, verified, category one application is awaiting review and approval of the Medical Executive Committee and the Board of Trustees. Under no circumstance may temporary privileges be granted longer than 120 days for applications under review.

D. EXISTING MEDICAL STAFF MEMBERS • An existing Medical Staff Member applying for additional clinical privileges may be granted temporary privileges provided such Physician meets the applicable privileging criteria.

SECTION 2. APPROVAL OF TEMPORARY CLINICAL PRIVILEGES

The CEO, or his or her designee, may grant temporary privileges upon the recommendation of the chair of the applicable department and the Chair of the Credentials Committee. Practitioners granted temporary privileges are subject to the same requirements and policies as Medical Staff members in all matters relating to their temporary clinical privileges.

SECTION 3. DENIAL OR TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

The inability to obtain temporary clinical privileges or termination or suspension of temporary clinical privileges will not constitute grounds for a Fair Hearing.
SECTION 4. APPLICATION PROCESS FOR LOCUM TENENS APPLICANTS

At a minimum, the following will be verified via the primary source (or equivalent source, such as the AMA profile) for all locum tenens applicants:

1. State licensure;
2. Medical school, internship/residency and fellowship (if applicable);
3. Board certification or Board Eligibility;
4. Most recent active hospital affiliation;
5. One current peer reference, preferably from a department chair, a training program or a peer from the same specialty;
6. National Practitioner Data Bank report,
7. All other applicable basic requirements for membership, as outlined in the Medical Staff Bylaws, Article I, Section 3,
8. Criminal Background Check; and
9. Idaho State Board of Pharmacy License; and,
10. Current State issued DEA.
SECTION 1. EMERGENCY PRIVILEGES

For the purposes of this section, an "emergency" is defined as a condition in which serious or permanent harm could result to a patient or in which the life of a patient is in imminent danger and any delay in administering treatment would add to that danger. In the case of an emergency, any Practitioner, to the degree permitted by his or her license and regardless of department, Medical Staff status or clinical privileges, will be permitted to do, and be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save the patient from serious harm.

SECTION 2. ORGAN HARVESTING TEAMS

Organ "harvesting teams" sanctioned or organized by a Joint Commission accredited acute care hospital will be automatically granted such Clinical Privileges as are appropriate in order to harvest organs provided that all such activities will be coordinated and supervised by an Active or Courtesy Medical Staff Member.

SECTION 3. DISASTER PRIVILEGES

A. DISASTER MANAGEMENT PLAN - In emergency and disaster circumstances where the hospital’s Emergency Management Plan has been activated, volunteer practitioners may be granted disaster privileges by the President of the Medical Staff, President Elect of the Medical Staff, Secretary/Treasurer of the Medical Staff, or the Credentials Committee Chair according to immediate availability in that order.

B. VERIFICATION - The Medical Staff recognizes that it is imperative that volunteer practitioners must have their identity verified by a representative from the Office of Medical Affairs prior to granting disaster privileges. Acceptable means of verification must include current license to practice plus a current picture ID (must be government-issued (state or federal). Acceptable government issued picture identification cards must be one of the following:
   1. state-issued driver’s license;
   2. military identification card;
   3. a current picture hospital identification card;
   4. a picture identification card issued by a regulatory agency (i.e. CMS or Joint Commission);
   5. identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT);
   6. identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such as authority having been granted by a federal, state or municipal entity); or
   7. verification by a member of the Saint Alphonsus Medical Staff that the individual has personal knowledge regarding the practitioner’s identity.
C. **Granting Disaster Privileges**: Following the verification process outlined in paragraph B. above, a representative of the Office of Medical Affairs will present the volunteer practitioner’s information and form of verification to the granting authority listed in paragraph 1. above. The granting authority may, based on the information submitted, grant or deny disaster privileges or request additional information.

D. **Announcement of Disaster Practitioners**: All practitioners granted disaster privileges will be issued a Saint Alphonsus identification badge with “Disaster Privileges Granted – Physician.” Practitioners granted Disaster privileges will be required to wear the Saint Alphonsus identification badge and the picture identification badge used in the verification process. The Office of Medical Affairs will also send a notice indicating the granting of disaster privileges.

E. **Deployment of Practitioners with Disaster Privileges**: Practitioners granted disaster privileges will be assigned and deployed as directed by the physician assigned to the Disaster Command Center.

F. **Concurrent Verification**: The Office of Medical Affairs will complete a thorough verification, consistent with the requirements for temporary privileges for an important patient care need. In the event that conflicting information is received, the authority that issued the disaster privileges will be immediately notified. If all information is consistent and appropriate, all verification documentation will be filed with the practitioner’s disaster privileges.

G. **Evaluation of Practitioners**: Within 72 hours of arrival, or as soon as feasible, practitioners will be evaluated using the Medical Staff’s peer evaluation form or other data available to determine clinical competence and continued granting of temporary privileges.

H. **Expiration of Disaster Privileges**: Disaster privileges will expire when the Hospital has deactivated the Emergency Management Plan or upon withdrawal of the issuing authority, whichever occurs first.
ARTICLE XII

PRIVILEGING

SECTION 1. BASIS FOR PRIVILEGES

A. CRITERIA FOR CLINICAL PRIVILEGES • Recommendations for clinical privileges will be
based upon the following:
1. current competence and clinical judgment;
2. professional ethics;
3. education, training and experience;
4. participation in continuing education;
5. meeting the basic qualifications for staff status;
6. ability to fulfill the responsibilities of Medical Staff membership;
7. use of the Hospital and/or ambulatory facilities;
8. compliance with the Medical Staff Bylaws, Policies and Rules and Regulations;
9. cooperation with other members, patients, hospital and/or ambulatory setting employees;
10. disruption, if any, of hospital and/or ambulatory setting operations;
11. physical, mental and emotional stability;
12. matters bearing on his or her ability and willingness to contribute to high quality patient care
   practices in the Hospital and/or ambulatory setting;
13. previously successful or currently pending challenges to any professional license or
   registration;
14. any voluntary relinquishment of such professional license or registration;
15. any voluntary or involuntary termination of Medical Staff privileges; and
16. any voluntary or involuntary limitation or reduction or loss of clinical privileges at this or
   another hospital and/or ambulatory setting.

SECTION 2. UNIFORM APPLICATION OF PRIVILEGING DETERMINATION

The basis for privileging determinations will be uniformly applied to all Applicants and will include
observed clinical performance and the documented results of quality assurance activities conducted
at the Hospital and/or ambulatory setting or other health care facilities. Clinical privileges will also
be based on pertinent information concerning clinical performance obtained from staff members,
peers and other sources, especially other institutions and health care settings where the Applicant
exercises or has exercised clinical privileges. This information will be added to and maintained in
the Applicant's credentials Hospital's file located in the Office of Medical Affairs established for a
staff member.
SECTION 1. PURPOSE

The purpose of this section is to describe the process used by the Medical Staff and the Board to assure that appropriate, comprehensive clinical criteria are developed and implemented for clinical privileges, i.e., the right to perform a procedure, method of treatment or other patient care services. This will help assure that clinical privileges will be granted to those medical staff members who are able to demonstrate current clinical competence. Criteria for clinical privileges are used by the Medical Staff and Board to define, in advance of requests for clinical privileges, how current clinical competence will be determined.

SECTION 2. POLICY

It is the policy of the Medical Staff of Saint Alphonsus Regional Medical Center that the Credentials Committee will determine if criteria for clinical privileges should be developed in the following situations.

A. PRIVILEGES THAT CROSS DEPARTMENT BOUNDARIES • When more than one department exercises the same privilege(s), thus making it necessary to define uniform criteria for the exercise of clinical privileges.

B. NEW EQUIPMENT • When new equipment is used which requires specialized training for safe and competent use.

C. NEW HOSPITAL PRIVILEGE • When practitioners request clinical privileges that are not within the scope of services at the Hospital; therefore, no criteria for the exercise of clinical privileges have been delineated.

SECTION 3. PROCEDURES FOR DEVELOPMENT OF PRIVILEGING CRITERIA

A. REQUESTS FOR NEW CLINICAL PRIVILEGES AND PRIVILEGES THAT CROSS DEPARTMENT BOUNDARIES • The medical staff member will be informed that the request cannot be processed until the Board has approved the addition of the new privilege(s) to the scope of services of the Hospital. The Medical staff member will be informed that if the privilege(s) are added to the scope of services, criteria must be established and approved prior to the acceptance of any requests for new clinical privileges. (Rev. 6/03)

B. REQUIRED DOCUMENTATION • The medical staff member who requests the new privilege(s) will be required to provide clinical information about the requested privilege(s), as well as the following:
1. a list of the training programs attended and references;
2. the specialties that may be involved and/or the types of practitioners who exercise this/these privilege(s);
3. standards for granting such privilege(s) from each related department society/board/academies; and
4. other information requested.

C. **DEPARTMENT CHAIR**

   1. All of the required documentation will be submitted to the Department Chair for review and development at the next regularly scheduled department meeting. The Department Chair, or designee, will research issues related to the new privilege(s), utilizing the general guidelines in Article VIII, Section 3G of these Bylaws, and to develop criteria to determine those who are competent to exercise the Clinical Privilege(s) according to the guidelines.

   2. The findings and recommendations will be forwarded to the Credentials Committee. The department will be given up to sixty (60) days to make a report/recommendation to the Credentials Committee after a request has been submitted by one of its members.

D. **CREDENTIALS COMMITTEE**

   1. The Department Chair will forward the request, and all supporting documentation, to the Credentials Committee, along with the information provided by the medical staff member.

   2. The Credentials Committee will review the information and appoint an ad-hoc committee or refer the issue to an existing medical staff department or committee for the development of criteria for privilege(s) as appropriate.

   3. When more than one department is involved in performing the requested privilege(s), the Credentials Committee will appoint an ad-hoc committee with at least one representative from each department involved. Additional specialties may be appointed to the ad-hoc committee as appropriate, after considering conflict of interest issues, if any.

   4. The ad-hoc committee or medical staff department will research issues related to the new privilege(s), utilizing the following general guidelines in Article VIII Section 3G and Article XII Section 1A of these Bylaws, and to develop criteria to determine those who are competent to exercise the Clinical Privilege(s) according to the guidelines. The ad-hoc committee or medical staff department will be given up to sixty (60) days to make a report/recommendation to the Credentials Committee.

   5. The Credentials Committee will consider the report from the ad-hoc committee or medical staff department, and make a written recommendation (including the rationale for the recommendation) to the Medical Executive Committee.

E. **MEDICAL EXECUTIVE COMMITTEE**

   The Medical Executive Committee will review the written recommendation of the Credentials Committee and make a final recommendation to the Board.

F. **BOARD OF TRUSTEES**

   The Board will make a final decision. In considering whether the scope of services would be expanded to include new privilege(s), the Board may consider factors, including but not limited to:

   1. the community and patient need;
   2. the capacity of the Hospital to support the new privilege(s) requested, including whether appropriate equipment, space, supplies, trained staff, scheduling and other necessary resources are reasonably available;
   3. quality of care issues;
   4. patient convenience;
5. reimbursement issues; and
6. any other business and patient care objectives of the Hospital which the Board believes are relevant to disposition of the request.

If approved by the Board, the privilege(s) will be added to the scope of services, along with the recommended criteria (if any) and practitioners may apply for the privilege(s).

G. **GENERAL GUIDELINES** • The following guidelines will be used in the development of privileging criteria. The purpose is to define the training, competence and experience required to perform the requested clinical privilege(s). An approved Privilege Criteria/Request form is attached hereto as Appendix A, for illustrative purposes. (Rev. 10/06)
   1. the type of basic education (degree) required to apply for the privilege(s) in question;
   2. whether the medical staff member must be board certified/eligible;
   3. the type and extent of formal training, such as type of residency, fellowship or other type of training;
   4. how much recent practice experience (within the past 12-24 months) in the practice area or related field the medical staff member or medical staff member must demonstrate;
   5. any continued didactic or hands-on training; either that is required;
   6. number and types of references that will be necessary to evaluate the Medical staff member or medical staff member's ability, judgment and current clinical competence; and
   7. special proctoring requirements or other criteria that the ad hoc committee, department/clinical section/committee, medical staff member feels is appropriate.

H. **EDUCATIONAL GUIDELINES** • The following educational guidelines apply unless otherwise specified. (Rev. 6/03)
   1. All training must have taken place in a postgraduate training program approved by one of the following, unless otherwise specified:
      a. American Medical Association (AMA);
      b. American Osteopathic Association (AOA);
      c. American Podiatric Medical Association (APMA); or
      d. Accreditation Council for Graduate Medical Education (ACGME)
      e. Canadian Royal College of Physicians and Surgeons
   2. All practice experience must have occurred within the past 24 months at an institution with formal quality improvement programs.
ARTICLE XIV  

IMPAIRED PHYSICIANS

SECTION 1. PURPOSE

It is the policy of Saint Alphonsus Medical Staff to properly investigate and act upon concerns that a Practitioner is suffering from impairment. This chapter provides a process for reporting concerns that a Practitioner is impaired and for investigating and acting on concerns that a Practitioner is impaired. Under the chapter, the Medical Staff takes into consideration the potential rehabilitation of the impaired Practitioner. The Medical Staff will conduct its investigation and act in accordance with state and federal law including, but not limited to, the Americans with Disabilities Act (ADA), when applicable.

SECTION 2. DEFINITION

For the purpose of this chapter, “impairment” is defined as a condition that adversely affects the ability of a Practitioner to provide medical care with reasonable skill and safety because of excessive use or abuse of drugs or medications, or mental or physical illness (including, but not limited to deterioration through the aging process, or loss of motor skills). The Medical Staff recognizes that this definition is broader than the ADA’s definition of “impairment.”

SECTION 3. PROCEDURE FOR REPORT AND INVESTIGATION

A. REPORT • If any individual has reasonable suspicion that a Practitioner is impaired, such person will provide a written report to the President or President Elect of the Medical Staff, the chairperson of the Practitioner’s department, or the Medical Director, Physician Relations. The report does not have to include conclusive proof of impairment, but will include a factual description of the incident(s) that led to the person’s concern.

B. INITIAL REVIEW • After receipt of a report concerning a Practitioner’s potential impairment, the recipient will evaluate whether it appears there is sufficient evidence to warrant further investigation. If so, the President of the Medical Staff, or his/her designee, may:
   1. meet personally with the Practitioner; and/or
   2. refer the report for investigation to an appointed investigator.

C. INVESTIGATOR • For the purposes of this policy, the Investigator will be assigned by the Medical Staff President and may include a Medical Staff Leader, Department Chair, Ad Hoc Committee or the Physician Professional Practice Committee. (Added 6/06)

D. INVESTIGATION • The investigation of a Practitioner’s potential impairment may include, but is not limited to, any of the following:
1. an interview with the Practitioner;
2. the review of any and all documents or other materials relevant to the investigation and the Practitioner’s potential impairment;
3. interviews with any and all individuals involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made are related to the performance of the Practitioner’s clinical privileges or scope of practice consistent with proper patient care at the Hospital, and that confidentiality is maintained;
4. the requirement that the Practitioner undergo a complete medical examination (including a psychiatric evaluation, if appropriate) as directed by the appointed Investigator, provided the exam is related to the performance of the Practitioner’s duties and privileges; and/or
5. a requirement that the Practitioner submit to a drug test/screening, in compliance with the Idaho Code, if appropriate to the potential impairment. (Rev. 6/06)

SECTION 4. CLASSIFICATION OF IMPAIRMENT

If the Investigator finds sufficient evidence that the Practitioner is impaired, the Investigator, in consultation with legal counsel, will determine the nature of the impairment and whether it is classified as a disability under the ADA. If the impairment is classified as a disability under the ADA, it will be subject to the provisions of Section 9, otherwise, it will be subject to the provisions of Section 10. (Rev. 6/06)

SECTION 5. RECOMMENDATION

The Investigator will evaluate the information gathered during its investigation and recommend action to the Medical Executive Committee for subsequent review and approval of the Board, through the Chief Executive Officer. The recommendation may include the Practitioner’s participation in an appropriate rehabilitation program as discussed in Section 9 of this policy. (Rev. 6/06)

SECTION 6. COMMUNICATION OF INVESTIGATION

Once the investigation is done and acted on, the Medical Staff will inform the person who filed the report. The Practitioner will be informed of the results of the investigation.

SECTION 7. CONFIDENTIALITY/DOCUMENTATION OF INVESTIGATION

The investigation and evaluation of a Practitioner’s potential impairment will be confidential and will be conducted pursuant to the Idaho Peer Review Statute, Idaho Code Section 39-1392, et seq. All participants in the investigation will refrain from discussing the investigation with anyone outside of the process described in this policy. The investigative report and recommendation will be included in the Practitioner’s Professional Practice file.

SECTION 8. NO ABUSE OF POLICY

Any Hospital employee or Practitioner who fabricates allegations of a Practitioner’s potential impairment may be subject to appropriate disciplinary action, up to and including termination of employment (for Hospital employees) or corrective action (for Practitioners).
SECTION 9. IMPAIRMENT CLASSIFIED AS A DISABILITY UNDER THE ADA

A. REASONABLE ACCOMMODATION • If the Practitioner’s impairment is a disability under the ADA, a determination by the Investigator, in consultation with legal counsel, will be made as to the following:
   1. whether a reasonable accommodation may be made such that the Practitioner would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of his or her medical staff appointment;
   2. whether such reasonable accommodation would create an “undue hardship” upon the Hospital in that the reasonable accommodation would be excessively expensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital’s operations or the provision of patient care; and
   3. whether the impairment constitutes a “direct threat” to the health or safety of the Practitioner, patients, staff or others within the Hospital. A direct threat must involve a significant risk of substantial harm based upon medical analyses and/or other objective evidence. If the Practitioner appears to pose a direct threat because of a disability, the Investigator must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.

B. VOLUNTARY AGREEMENT • If it is determined that a reasonable accommodation may be made as described above, attempts will be made to work out a voluntary agreement with the Practitioner, so long as the arrangement would neither constitute an undue hardship upon the Hospital or create a direct threat, also as described above. The Chief Executive Officer will approve any agreement before it becomes final and effective.

C. OTHER RECOMMENDATION • If the Hospital is unable to make a reasonable accommodation or if a voluntary agreement cannot be reached with the Practitioner, the Investigator, via the Medical Executive Committee, will make a recommendation and report to the Board of Trustees, through the Chief Executive Officer, as to appropriate action to be taken. If the Investigator’s recommendation would provide the Practitioner with a right to a hearing as described in the Medical Staff Bylaws, the Chief Executive Officer will promptly notify the Practitioner of the recommendation in writing, by certified mail, return receipt requested. The recommendation will not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the Medical Staff Fair Hearing Plan.(Rev. 6/06)

SECTION 10. IMPAIRMENTS THAT ARE NOT DISABILITIES UNDER THE ADA

A. RECOMMENDATION • If the impairment is not a disability under the ADA, depending on the nature and severity of the impairment, the Investigator’s recommendation may include, but is not limited to, any of the following:
   1. If the Practitioner acknowledges the existence of impairment and agrees to fully cooperate and comply with an appropriate rehabilitation plan, the Practitioner may be placed on a medical leave subject to approval by the CEO and the President of the Medical Staff. Any such medical leave will be subject to the provisions of Section 11 below;
   2. If the Practitioner either denies the existence of impairment or fails to fully cooperate with the required course of rehabilitation, a review will be requested under the Medical Staff Bylaws Corrective Action Plan; or
   3. If the criteria under Section 8 of the Corrective Action Plan exist, precautionary suspension will be imposed.
SECTION 11. REHABILITATION AND REINSTATEMENT

A. **PRACTITIONER RECOVERY NETWORK** • If appropriate, the impaired Practitioner will be referred to the Idaho Medical Association Practitioner Recovery Network (PRN), which will assist the Practitioner in locating a suitable rehabilitation program. The Practitioner may be placed on a medical leave for purposes of participation in the program. A Practitioner will not be reinstated until it is established, to the Hospital’s satisfaction, that the Practitioner has successfully completed a PRN-sanctioned program.

B. **ELIGIBILITY FOR REINSTATEMENT** • Upon sufficient proof that a Practitioner who has been found to be suffering from impairment has successfully completed a PRN-sanctioned rehabilitation program, the Hospital at its discretion, may consider that Practitioner eligible for reinstatement to the Medical Staff. Sufficient proof includes but is not limited to a letter from the director of the rehabilitation program where the Practitioner was treated confirming that:

1. The Practitioner participated in the program;
2. The Practitioner is in compliance with all of the terms of the program;
3. Whether, in the director's opinion, the Practitioner is capable of resuming medical practice and providing continuous, competent care to patients; and
4. Whether, in the opinion of the director, the Practitioner should participate in an aftercare program.

C. **REINSTATEMENT** • In considering an impaired Practitioner's eligibility for reinstatement, the Hospital must make a decision in the best interest of patient care. Assuming all of the information received indicates that the Practitioner is rehabilitated and capable of resuming care of patients, the following additional precautions should be taken when restoring clinical privileges, the Practitioner:

1. must identify another Practitioner who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability;
2. will be required to obtain periodic reports from his or her primary treating physician or psychologist or monitoring physician for a period of time specified by the Chief Executive Officer, President and the President Elect of the Medical Staff, verifying that the Practitioner is continuing treatment or therapy, and that his or her ability to treat and care for patients in the Hospital is not impaired;
3. exercise of clinical privileges in the Hospital will be monitored by the department chairperson or designee; and
4. must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Medical Staff President or the chairperson of the Practitioner’s department.

SECTION 12. AFTER-CARE PROGRAMS

Any after-care programs and/or monitoring will be coordinated by the PRN based on the after care program prescribed by the director of the rehabilitation program. In order to assure appropriate aftercare treatment, the impaired Practitioner will be required to sign and comply with an aftercare contract with the PRN.
SECTION 1. PURPOSE AND PHILOSOPHY STATEMENT

It is the policy of the Saint Alphonsus Regional Medical Center Medical Staff ("Medical Staff") that all Practitioners as defined in the Medical Staff Bylaws will treat others with respect, courtesy and dignity and will conduct themselves in a professional and cooperative manner. It is intended that all Practitioners at Saint Alphonsus Regional Medical Center ("Hospital") have productive careers that are not blemished by disruptive behavior. The Medical Staff also recognizes that disruptive behavior is contrary to the mission of the Hospital and is not conducive to the safety of patients. This policy is intended to set forth a procedure for resolution of complaints of disruptive conduct and/or unlawful harassment reported or made by Hospital employees, other Practitioners, patients or other individuals about a Practitioner. The Medical Staff desires this policy to provide a collegial procedure to be used, when appropriate, to address conduct of Practitioners. However, in certain circumstances, conduct that violates this policy may constitute grounds for corrective action under the Bylaws and this policy may be bypassed.

SECTION 2. DEFINITIONS

A. SEXUAL HARASSMENT • It is a violation of both state and federal law for a Hospital employee to be subjected to sexual harassment in the workplace. Sexual harassment, as prohibited by law, is distinguished from a voluntary sexual relationship by the elements of coercion, threat, unwanted attention, unwelcome or unwanted sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Verbal or physical conduct of a sexual nature constitutes sexual harassment when any of the following things occur:
   1. Submission to or rejection of such conduct is either implicitly or explicitly made a term or condition of employment or participation in Hospital activities.
   2. Submission to or rejection of such conduct by an individual is used as a basis for evaluation in making personnel decisions affecting an individual.
   3. Conduct unreasonably interferes with the performance or work of the individual or creates an intimidating, hostile or offensive work environment.

B. DISRUPTIVE CONDUCT • For purposes of this policy, disruptive conduct includes, but is not limited to, any of the following:
   1. Using threatening or abusive language directed at an individual or regarding another individual, including patients, nursing staff, other Hospital personnel or Practitioners (e.g., belittling, berating and/or threatening an individual).
   2. Making degrading, demeaning or insulting comments regarding patients, nursing staff, other Hospital personnel or the Hospital.
   3. Using profanity, racial slurs or similarly offensive language.
4. Verbal, non-verbal or physical interaction with another individual that is reasonably perceived as threatening, intimidating or disruptive to the orderly operations of the Hospital.

5. Addressing concerns about clinical judgment or dissatisfaction with the performance of another individual in the medical record or by other inappropriate means (instead of through direct and professional contact with the individual or through Medical Staff or Hospital policies).

6. Refusing to utilize the electronic health record or any informational technology required for safe patient care or refusing to participate in training associated with the electronic health record or any informational technology required for safe patient care.

SECTION 3. SCOPE OF POLICY

A. PLACE OF CONDUCT THAT MAY VIOLATE POLICY • This policy is intended to address conduct that occurs within the Hospital. However, if the conduct is egregious or could adversely affect the collegial atmosphere and orderly operations of the Hospital, even if the conduct occurs outside the Hospital or clinical setting, the Medical Staff may choose to invoke this policy.

B. APPLICATION TO COMPLAINTS ABOUT PRACTITIONERS • This policy applies to complaints of unlawful harassment or disruptive behavior made by patients, Hospital employees, Practitioners or others about any Practitioner. Complaints about the conduct of Practitioners, including Hospital-employed Practitioners, will be handled in accordance with this policy. Complaints about the conduct of other Hospital employees will be handled in accordance with the Hospital’s applicable Human Resource Policies and Procedures.

C. CORRECTIVE ACTION • This policy outlines a collegial procedure to attempt to address disruptive or unlawful harassing conduct by a Practitioner, and invoking the policy does not itself entitle a Practitioner to rights under the Bylaws’ Fair Hearing Plan. However, notwithstanding the Medical Staff’s desire to try to address these issues through the collegial procedure in this policy, this policy does not preclude immediate invoking of the Bylaws’ Corrective Action Plan process at any time, if it is determined that the Practitioner’s conduct so warrants. For example, if there is a single severe incident of conduct, or a repetitive pattern of conduct that is egregious, this collegial procedure may be bypassed, and the Corrective Action Plan may be invoked. (If the Corrective Action Plan is invoked and the Practitioner's conduct results in an adverse action as defined in the Bylaws, then the Practitioner would be entitled to such rights as are outlined in the Fair Hearing Plan.)

D. PEER REVIEW CONFIDENTIALITY • The Investigation of a Practitioner under this policy is considered and intended by the Hospital and Medical Staff to be within the scope of Peer Review confidentiality as provided under Idaho Code Section 39-1392 et. seq. and Bylaws Article VII, Section 3.

SECTION 4. PROCEDURES FOR DOCUMENTING AND TRIAGING EVENT REPORTS/COMPLAINTS

A. Reporting Conduct Potentially Violative of this Policy. Complaints alleging disruptive conduct or unlawful harassment concerning a Practitioner should generally be reported and documented in the Hospitals computerized event reporting system. These reports/complaints, as well as any complaints which are otherwise reported or made, will be forwarded to the Event Report Triage Committee. The Event Report Triage Committee will review and triage them consistent with the
guidelines in this policy.

B. Event Report Triage Committee. All incident reports/complaints, and other complaints received through other sources regarding Practitioners will be reviewed by the Risk Management Department and the President of the Medical Staff to verify basic information. Complaints which require further review and investigation will initially be evaluated and triaged by a committee composed of the Chief Medical Officer, Vice President Quality and Patient Safety and/or a representative from the Office of Medical Affairs (“OMA”), the Director of Nursing Operations, the President-elect or Secretary/Treasurer of the Medical Staff, the President of Hospital or his or her designee, and the Director of Risk Management or designee.

C. General Triage Guidelines. Issues are generally triaged by the Event Report Triage Committee as follows and may be forwarded as listed below:

- All anonymous reports/complaints are retained for tracking and trending. Anonymous reports/complaints will be assessed by the Event Report Triage Committee and may be referred for such investigation as is possible to undertake under the circumstances.
- Reports/complaints that are evaluated as predominantly a result of system issues and involve a Practitioner who rarely has complaints filed against him or her may be referred to the manager of the area where the complaint occurred for further investigation and resolution.
- Reports or complaints may be forwarded to the Practitioner's Department Chair.
- Reports/complaints that are evaluated as predominantly system issues may be referred to other Committees or individuals (such as the manager of the area where the incident occurred) for follow up and or disposition.
- Reports/complaints that are deemed to potentially involve a quality of care component may be also forwarded for peer review.
- Reports/complaints that involve a Practitioner who has numerous or repetitive complaints may be referred to the PPPC.
- Any reports/complaints of egregious behavior, no matter the frequency of the complaints against the Practitioner, are referred to OMA for distribution to the Chair of the PPPC, the President and President-elect of the Medical Staff, the Chief Medical Officer, Vice President Quality and Patient Safety, the CEO, or their respective designees. Complaints of unlawful harassment involving hospital employees including employed Practitioners, will also be referred to the Manager of Employee Relations or other appropriate designee of Human Resources.

C. Practitioner Notification. The Chair of the PPPC will inform the Practitioner of the receipt of the report/complaint within a reasonable time after receipt and whenever possible within seven (7) days of the completion of the review of the complaint by the Event Report Triage Committee. The Practitioner may review the complaint in the OMA after acknowledging the Medical Staff policy prohibiting retaliation against the Complainant, as more specifically set forth in Section 10 of this policy. No copies of the documentation will be made by or for the Practitioner. The complaint and accompanying documentation may not be removed from the OMA by the Practitioner.

SECTION 5: FURTHER EVALUATION OF REPORT/COMPLAINT

A. Referral to the PPPC or other Investigator. The Event Report Triage Committee will consider whether it is appropriate to attempt to address and resolve the issue at an informal level directly
with the Practitioner, or if further investigation is warranted. The President-Elect of the Medical Staff may also notify the Department Chair and decide the type of involvement in the investigation for the Department Chair based on the report/complaint.

1. When evaluating how to proceed, the Event Report Triage Committee will consider the facts and circumstances alleged, including but not limited to the severity and frequency of the complained of conduct, information available that verifies the conduct (such as witnesses reports confirming the conduct), any prior complaints about the Practitioner and the Practitioner’s attitude and willingness to professionally address the concerns raised, if known.

2. If the Event Report Triage Committee determines the matter cannot be or was not able to be resolved informally, or if it is a repeated incident or an egregious incident, or number of incidents, the Event Report Triage Committee will forward the complaint to the PPPC or another appropriate investigator(s) (“Investigator”) to complete a review of the report/complaint and conduct an investigation. Alternatively, if the Event Report Triage Committee feels the allegations warrant, it may refer a matter to one of the individuals listed in the Bylaws for precautionary suspension and/or initiation of an investigation under the Corrective Action Plan. If that occurs, the process outlined in that Corrective Action Plan will then apply to the review of the matter, rather than this policy.

3. Risk Management, the Event Report Triage Committee or PPPC will investigate most complaints; however, if another Investigator is chosen, consideration will be given to the source of the report/complaint. For example, an employee report/complaint could be investigated by the HR Employee Relations Manager or designee, a Practitioner complaint could be investigated by a Department Chair, and a patient complaint could be investigated by the appropriate nursing leader or a designated members of the PPPC).

B. Evaluation of All Reports/Complaints. Anonymous reports or complaints will be followed up to the extent possible. Requests that a complaint is “for information purposes only” or that “nothing should be done” generally should not be accommodated. If a Complainant wishes to withdraw the complaint, or makes a further report that he or she reported inaccurate information, the withdrawal and/or change will be documented and signed. Withdrawal of the complaint will not, however, affect the Medical Staff or Hospital’s ability to proceed with an investigation or other action pursuant to this policy, or the Medical Staff Bylaws, as appropriate.

C. Investigation Process.

1. The Investigator(s) will conduct as thorough of an investigation as possible, in a manner that is reasonably confidential under the circumstances. Whenever feasible, the Investigator will conduct the investigation within ten (10) business days of receiving the report/complaint from the Event Report Triage Committee or as soon as is reasonably possible.

2. The investigation will include interviews with any witnesses and discussions with both the Complainant and the Practitioner, who will be advised of the contents of the complaint and be given an opportunity to respond to the allegations.

3. The Investigator will determine whether the complained of conduct occurred or likely occurred. The Investigator will prepare a written report and summary of the investigation and provide it to the PPPC. The Investigator may also be asked to meet with the PPPC Chair or its members to answer questions regarding the report and conclusions.

4. If the Investigator finds that in his or her judgment the weight of the evidence is that the complained of conduct has occurred and this policy has been violated, he or she will inform the PPPC and the matter will proceed as outlined in Section 6.

5. If the Investigator finds that in his or her judgment the weight of the evidence is that the complained of conduct did not occur and/or did not violate this policy, the PPPC will be so advised and the Complainant and the Practitioner will be notified in writing by the PPPC.
Chair. If there is information which may indicate that other policies have been violated then the PPPC will make a referral for further investigation and action to other appropriate Medical Staff or Hospital bodies.

SECTION 6: FINAL MEETING WITH THE PRACTITIONER AND COMMUNICATION OF FINDINGS

1. If the Investigator determines there has been a policy violation, the Practitioner will be required to meet with the PPPC and any other appropriate individuals invited by the PPPC Chair.

2. The Chair of the PPPC will inform the Practitioner of the findings of the Investigation at the meeting and will give the Practitioner an opportunity to respond at this required meeting.

3. The Practitioner may review all the documentation in the OMA, but he or she may not copy the documentation. He or she will also be reminded of the “no retaliation” policy set forth in Section 10 below. If the Practitioner does not present additional information which convinces the majority of the PPPC members present that he or she did not violate this policy, the Practitioner will be informed by the PPPC Chair of this conclusion. He or she will also be informed of the remedial action which will be imposed (unless the PPPC needs to undertake further deliberation regarding the matter). The PPPC will write a formal notification to the Practitioner. The final findings and written notification to the Practitioner by the PPPC Chair should be completed within seven (7) calendar days after the meeting with the Practitioner. If the Practitioner wishes to submit a written response to the meeting, the written response must be received in OMA within forty-eight (48) hours of the conclusion of this final meeting with the Practitioner.

4. Any documentation regarding the investigation, including the Investigative Report, and the PPPC Chair’s notification of the Practitioner’s findings of the Investigation will remain in the OMA in the Practitioner’s Professional Practice File. The investigation documentation is considered peer review protected information under Idaho Code section 39-1392 and will remain as confidential as possible to the extent permitted by law and the Bylaws.

5. In addition to informing the Practitioner as set forth above, at the conclusion of the investigation, the PPPC Chair will notify the Complainant in writing that the matter was investigated and if applicable, may generally state that remedial action has been taken (without indicating the specific action taken). The President of the Medical Staff, Chief Medical Officer, Vice President Quality and Patient Safety and the Hospital CEO should be copied on the final notification to the Practitioner and the Complainant.

SECTION 7: REMEDIAL OPTIONS FOR POLICY VIOLATIONS

A. Remedial Measures. If the majority of the PPPC members who have reviewed the investigative report decide that the Practitioner who is subject of the investigation has violated this policy, the PPPC will take appropriate remedial measures. Remedial measures such as verbal or written warning are documented in the Practitioner’s Professional Practice File. All other remedial measures listed below are documented in the Practitioner’s Credentials File. These may include, but are not limited to any of the options listed below. When considering an appropriate remedial measure, consideration may be given to the facts and circumstances, including the severity and frequency of the complained of conduct, any prior complaints, the Practitioner’s willingness to acknowledge the inappropriateness of the complained of behavior and to correct such behavior.
and the effect of the remedial measures in ensuring the complained of conduct ceases and does not reoccur.

1. **Verbal Warning.** Requiring that the Practitioner cease the conduct which gave rise to the complaint.

2. **Written Warning.** Letters of admonishment, reprimand or warning, requiring that the Practitioner cease the conduct that gave rise to the complaint.

3. **Suspension.** Suspension for one (1) to fourteen (14) days of all or a portion of the clinical privileges of the Practitioner.

4. **Counseling, Education and Training.** A requirement that the Practitioner attend specified counseling or education and training regarding sexual harassment or sensitivity, anger management, other appropriate counseling, education and training including referral to the Idaho Physicians’ Recovery Network or other appropriate referral for follow-up approved by the PPPC.

**B. Consequences of Non-compliance with the Investigative Process or Remedial Measure.** Any failure of a Practitioner to cooperate in providing material information for the Investigation as requested, to appear at meetings as requested, to comply with and abide by the recommended remedial measures, or repeated violations of the policy, may each in and of themselves be an independent cause for immediate imposition of one of the remedies below and/or referral for corrective action under the Bylaws.

**SECTION 8. NO ABUSE OF POLICY TOLERATED**

Any Hospital employee or Practitioner who makes up facts to falsify allegations of violations of this policy against any Practitioner will be subject to appropriate disciplinary action up to and including termination of employment (for Hospital employees) or corrective action (for Practitioners).

**SECTION 9. NO RETALIATION POLICY**

The Medical Staff and Hospital will not tolerate any retaliation against, or any intimidation of, any person who has complained of conduct in violation of this policy or who has cooperated with an investigation. Any violation of the no retaliation policy may be an independent cause for corrective action under the Bylaws, regardless of the merit of the original complaint. Examples of conduct or behavior that may be considered a violation of the no retaliation policy include but are not limited to the following:

- Approaching the complainant in response to the complaint (unless permitted or requested by the Event Report Triage Committee or the PPPC).
- Discussing the complaint and/or complainant with others including but not limited to making negative comments about the complainant, witnesses or the process used to investigate the complaint.
- Any action or conduct that adversely affects the complainant's work environment.

**SECTION 10. REAPPOINTMENT**

The duration of reappointment may be shortened in order to complete assessment or investigation of complaints, to allow time to complete the other processes outlined in this policy or to monitor the effectiveness of remedial measures. Shorter reappointments may or may not be extended to a maximum of two (2) years at the completion of the process, at the total discretion of the designated entities normally involved in the reappointment process (Department Chairs, Credentials Committee, MEC, and the Board).
SECTION 1. INVESTIGATION PROCEDURES

A. ROUTINE PROCEDURE FOR CONDUCTING AN INVESTIGATION • A written request for an investigation will be addressed to the Medical Executive Committee whenever, on the basis of information and belief, the President of the Medical Staff, the Chair of a Department, the Chair of the Credentials Committee, a majority of the Credentials or Medical Executive Committee, the Chair of any other committee or a majority of that committee, the Chair of the Board or the Chief Executive Officer has cause to question, with respect to a Practitioner any one of the following:
1. the practitioner’s clinical competence;
2. the practitioner’s known or suspected violation of the Bylaws, policies, or procedures of the Hospital or of the Medical Staff; or
3. the practitioner’s behavior or conduct is lower than the standards of the Hospital or disruptive to the orderly operations of the Hospital or its Medical Staff, including his or her inability to work harmoniously with others.

The written request to the Medical Executive Committee will make specific reference to the activity or conduct that gave rise to the request.

B. NOTIFICATION OF THE CHIEF EXECUTIVE OFFICER • The Chair of the Medical Executive Committee will promptly notify the Chief Executive Officer in writing of all requests for investigation regarding a Medical Staff Member received by the Medical Executive Committee and keep the Chief Executive Officer fully informed of all action taken in connection with the request for investigation.

C. MEDICAL EXECUTIVE COMMITTEE RESPONSIBILITIES • The Medical Executive Committee will meet as soon after receiving the request as practical, and will do one of the following based on the circumstances:
1. If, in the opinion of the Medical Executive Committee, the request for investigation contains information sufficient to warrant action or a recommendation, the Medical Executive Committee, at its discretion, will take the appropriate action or make the appropriate recommendation as provided in Section 2B of the Corrective Action Plan, with or without a personal interview with the practitioner, at its discretion.
2. If, in the opinion of the Medical Executive Committee, the request for investigation does not at that point contain information sufficient to warrant action or a recommendation, the Medical Executive Committee will investigate the matter itself or assign one of the following to immediately investigate the matter (the “Investigator”):
   a. the Credentials Committee;
   b. the Physician Professional Practice Committee;
   c. an appointed subcommittee of the Medical Executive Committee; or
   d. an appointed Ad Hoc Committee. The Ad Hoc Committee will consist of at least three (3) persons who may or may not be Medical Staff Members. The Committee
will not include partners or associates of the affected Practitioner or of any members of the Medical Executive Committee.

3. The Investigator will have available the full resources of the Medical Staff and the Hospital to aid in their work, as well as the authority to use outside consultants as required. The practitioner with respect to whom an investigation has been requested will have an opportunity to meet with the Investigator before it makes its report. At this meeting (but not as a matter of right, in advance of it) the practitioner will be informed of the general nature of the evidence supporting the investigation requested and will be invited to discuss, explain or refute it. This interview will not constitute a hearing, and none of the procedural rules provided in the Bylaws including its Fair Hearing Plan with respect to hearings will apply. A record of such interview will be made by the Investigator and be included with its report to the Medical Executive Committee. (Rev. 8/06)

4. At any time during any investigation in this Section 1C, the clinical privileges of the Practitioner being investigated may only be suspended as provided in Section 5 and 6 of the Corrective Action Plan. The investigation will be completed within fourteen (14) days of the date it is imposed if a suspension under Section 5 of this Corrective Action Plan is in effect, and within sixty (60) days of the date the suspension is imposed if a suspension under Section 6 of the Corrective Action Plan is in effect. The sixty (60) day time period may be extended by the Board for good cause.

SECTION 2. PROCEDURE FOLLOWING COMPLETION OF INVESTIGATION

Following the investigation, the Medical Executive Committee will determine if corrective action is appropriate.

A. **CORRECTIVE ACTION NOT WARRANTED** • If the Medical Executive Committee determines that corrective action is not appropriate, it will issue a written report to that effect.

B. **CORRECTIVE ACTION WARRANTED** • If the Medical Executive Committee determines that corrective action is appropriate, it may take any one or more of the following actions:

1. issue a written warning;
2. issue a letter of reprimand;
3. impose terms of probation;
4. impose a requirement for review and/or consultation;
5. recommend a decrease, restriction or modification of clinical privileges;
6. recommend suspension of clinical privileges for a term;
7. recommend revocation of Medical Staff appointment; and/or
8. take such other actions or make such other recommendations, as the Medical Executive Committee deems appropriate.

SECTION 3. ADVERSE RECOMMENDATIONS

Any recommendation by the Medical Executive Committee for a decrease, restriction or modification of clinical privileges, for suspension of clinical privileges or for revocation of Medical Staff appointment will be an adverse recommendation. Such a recommendation will be forwarded to the Chief Executive Officer who will promptly notify the affected practitioner by
Special Notice and as provided in the Fair Hearing Plan. The Chief Executive Officer will then hold the recommendation until after the individual has exercised or has been deemed to have waived his or her rights as provided in the Fair Hearing Plan. At the time the individual has been deemed to have waived his or her rights as provided in the Fair Hearing Plan, the Chief Executive Officer will forward the recommendation of the Medical Executive Committee, together with all supporting documentation, to the Board. The Chair of the Medical Executive Committee or his or her designee will be available to answer any questions that may be raised by the Board with respect to the recommendation.

SECTION 4. NON-ADVERSE RECOMMENDATIONS

If the action of the Medical Executive Committee is less severe than an adverse recommendation as set forth above, the action will take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefore will be made to the Board through the Chief Executive Officer and the action will stand unless modified by the Board. In the event the Board does not accept the recommendation of the Medical Executive Committee and reduces clinical privileges, suspends clinical privileges or revokes Medical Staff appointment, the Chief Executive Officer will so notify the practitioner by Special Notice as provided in the Fair Hearing Plan. In the event the practitioner exercises his or her rights to a hearing as a result of such adverse Board action, the decision of the Board will not be final unless the Board does not modify its decision after it has received the Hearing Panel reports, and if applicable, Review Panel reports and other relevant information.

SECTION 5. SUSPENSION FOR PURPOSES OF INVESTIGATION

At any time during an investigation, the Chair of the Medical Executive Committee may suspend all or any part of the clinical privileges of the practitioner. The suspension will be deemed to be administrative in nature, for the protection of Hospital patients and will not indicate the validity of the charges. It will remain in effect during the investigation only and for a period not longer than fourteen (14) days.

SECTION 6. SUSPENSION FOR REASONS OF PATIENT SAFETY

The Chair of the Medical Executive Committee, Practitioner’s Department Chair, Chair of the Credentials Committee, the Chair of the Physician Professional Practice Committee, the Chief Executive Officer, or the Chair of the Board will each have the authority to suspend all or any portion of the clinical privileges of a practitioner whenever such action is, in the opinion of the individual exercising the right, in the best interest of patient care or safety in the Hospital, or the continued effective operation of the Hospital. Such suspension will be for the purpose of investigation only and will not imply any final finding of responsibility for the situation that caused the suspension. Such precautionary suspension will become effective immediately upon imposition, will immediately be reported in writing to the Chief Executive Officer, and will remain in effect unless or until modified by the Medical Executive Committee or the Board. A suspension of clinical privileges pursuant to this section will not entitle a Practitioner to any procedural rights afforded by the Bylaws including its Fair Hearing Plan. (Rev. 8/06)
A. **PRECAUTIONARY SUSPENSION** • The individual who exercises his or her authority under this Section of this Corrective Action Plan to precautionary suspend a person appointed to the Medical Staff will immediately report his or her action to the Chair of the Medical Executive Committee. At that point the Medical Executive Committee will take such further action as is required in the manner specified under this Corrective Action Plan, unless an investigation is already pending on the same subject matter.

B. **PATIENTS OF SUSPENDED PRACTITIONER** • Immediately upon the imposition of a precautionary suspension, the appropriate Department Chair or, in his or her absence, the Chair of the Medical Executive Committee will assign to another person appointed to the Medical Staff responsibility for care of the suspended practitioner’s patients still in the Hospital at the time of such suspension until such time as they are discharged. The wishes of the patient will be considered, where feasible, in choosing a substitute. It will be the duty of the Chair of the Medical Executive Committee and the Department Chair to cooperate with the Chief Executive Officer in enforcing all suspensions.

**SECTION 7. AUTOMATIC SUSPENSION AND VOLUNTARY RELINQUISHMENT OF CLINICAL PRIVILEGES**

Any individual whose privileges are automatically terminated or voluntarily relinquished as set forth below, and as provided in the Medical Staff Bylaws and Policy & Plans, will not be entitled to any of the procedural rights outlined in the Bylaws and Fair Hearing Plan. (Added 8/06)

A. **SUSPENSION OF LICENSE** • A practitioner whose license, certificate or other legal credential authorizing him or her to practice his or her profession in this State is revoked, modified or suspended, will immediately and automatically be suspended from his or her Medical Staff Membership and from exercise of clinical privileges in the Hospital. If such license is partially limited or restricted, clinical privileges within the scope of such limitation or restriction will be automatically suspended. The automatic suspension provided for in this section will continue until the license, certificate or other legal credential authorizing the practitioner to practice his or her profession in the state is restored.

B. **DRUG ENFORCEMENT ADMINISTRATION (DEA) SUSPENSION** • Practitioners whose DEA number or other right to prescribe controlled substances is revoked or suspended will immediately and automatically be suspended from his or her Medical Staff Membership and from exercise of clinical privileges in the Hospital. If such number or other right to prescribe controlled substances is partially limited or restricted, clinical privileges within the scope of such limitation or restriction will be automatically suspended. The suspension provided for in this section will continue until such time as the practitioner's DEA number or other right to prescribe controlled substances is restored.

C. **FAILURE TO MAINTAIN MEDICAL RECORDS** • Failure to maintain medical records as outlined in the Medical Staff Bylaws, Organization Manual and Policy & Plans will be considered a voluntary relinquishment of Medical Staff Membership and all clinical privileges. The practitioner, after completion of his or her records, may be reinstated as outlined in Chapter I of the Medical Staff Policy & Plans.
D. **FAILURE TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE** • A practitioner who fails to satisfy the professional liability insurance requirements of the Bylaws or other Medical Staff policy will immediately and automatically be suspended from his or her Medical Staff Membership and from the exercise of clinical privileges in the Hospital. Such suspension will continue until such time as the person provides to the satisfaction of the Medical Executive Committee proof of professional liability insurance in accordance with the Bylaws and Medical Staff Policy & Plans.

E. **EXCLUSIVITY POLICY** • The clinical privileges of a practitioner subject to the exclusivity policy in the Bylaws will be deemed to automatically terminate upon termination of the exclusive contract with the Hospital or upon the termination of his or her contract with the group holding the exclusive contract with the Hospital.

F. **SPECIAL CONFERENCE** • Medical Staff Members who fail to attend a Special Conference set forth in the Bylaws after notice as specified in the Bylaws (unless excused by the Medical Executive Committee after showing of good cause) will be considered to have voluntarily relinquished Medical Staff Membership and clinical privileges. Membership and clinical privileges will automatically be reinstated if the Medical Staff Member thereafter, within fourteen (14) days of the time set for the first Special Conference, requests and participates in a rescheduled Special Conference after receiving a second notice scheduling another Special Conference.

G. **REAPPOINTMENT FORM** • A Practitioner who fails to return the Reappointment Form or information required in the reappointment packet within the timeframe specified by the Credentials Committee will be deemed to have voluntarily resigned from the Medical Staff and this will result in automatic termination of Medical Staff status together with all Clinical Privileges at the expiration of such Practitioner’s current term of appointment; provided, however, that no automatic termination will be effective unless the Medical Staff Member has been provided written notice of this failure to provide the necessary information. (rev 4/07)

**SECTION 8. CARE OF PRACTITIONER'S PATIENTS WITH AUTOMATIC SUSPENSION OR VOLUNTARY RELINQUISHMENT OF PRIVILEGES**

Immediately upon the voluntary relinquishment/automatic suspension of a practitioner’s privileges pursuant to Section 7 of the Corrective Action Plan, the appropriate Chair or, in his or her absence, the President of the Medical Staff, will assign to a Medical Staff member responsibility for the care of the practitioner’s patients still in the Hospital at the time of such suspension or voluntary relinquishment until such time as they are discharged. The wishes of the patient will be considered, if feasible, in choosing a substitute. It will be the duty of the President of the Medical Staff and the Chair to cooperate with the Chief Executive Officer in enforcing all such automatic suspensions or voluntary relinquishment of privileges. (Rev. 8/06)

**SECTION 9. NO PROCEDURAL RIGHTS**

Any individual whose privileges are automatically terminated or voluntarily relinquished will not be entitled to any of the rights as outlined in the Bylaws and Fair Hearing Plan.
ARTICLE XVII    FAIR HEARING

SECTION 1. INITIATION OF AND RIGHT TO HEARING

A. GROUNDS FOR HEARING • The following conditions are the only grounds that constitute the right to a hearing:
   1. Denial or revocation of initial medical staff appointment;
   2. Denial or revocation of medical staff reappointment;
   3. Denial or restriction of initial clinical privileges;
   4. Denial of requested increased clinical privileges;
   5. Involuntary restriction, reduction or suspension of clinical privileges;
   6. Individual application of, or individual changes in, mandatory concurring consultation requirement; or
   7. Suspension of medical staff appointment or clinical privileges in excess of fourteen (14) days, except for those matters that constitute grounds for an automatic suspension as provided herein.

B. ADVERSE ACTION • Actions outlined above are deemed an “adverse recommendation” or “adverse action” as such terms are used herein and in the Bylaws and Corrective Action Plan.

C. RIGHT TO HEARING AND PURPOSE OF HEARING • A Practitioner will be entitled to one formal hearing whenever a recommendation adverse to him or her has been made by either the Medical Executive Committee or the Board regarding those matters enumerated in section 1, A of this Article. The Practitioner will also be entitled to a formal hearing before the Board enters a final decision if the Board rejected a favorable recommendation by the Medical Executive Committee those matters enumerated in section 1, A. The purpose of the hearing will be to recommend a course of action to those acting for the Hospital, whether the Medical Staff or Board, and the duties of the Hearing Panel will be so defined and so carried out.

SECTION 2. LIMITATION ON HEARING RIGHTS

The matters for which a hearing is available to a Practitioner are limited to those enumerated above. Neither voluntary nor automatic relinquishment of appointment or clinical privileges nor the summary suspension of clinical privileges, as provided for in these Bylaws and this Fair Hearing section will constitute grounds for a hearing, but will take effect without hearing or appeal. Additionally, a Practitioner who is denied an application as a result of failing to meet the Basic Qualifications for Membership and/or the criteria and requirements of the department in which the Practitioner seeks appointment will not be entitled to the procedural rights set forth herein.
SECTION 3. NOTICE OF RECOMMENDATION AND PRACTITIONER RIGHTS FOR HEARING

When a recommendation is made which, according to this Fair Hearing section Plan, entitles an individual to reconsideration of his or her application or a formal hearing prior to a final decision of the Board on that recommendation, the Practitioner will promptly be given Special Notice by the Chief Executive Officer. This Special Notice will contain a statement of the recommendation made and a statement of the reasons for the recommendation. If pertinent, all patient records or information supporting the recommendation will be identified. This statement may be amended or added to at any time, so long as the material is relevant to the continued appointment or clinical privileges of the Practitioner requesting the hearing. The Practitioner will have sufficient time to study this additional information. Such Practitioner will have thirty (30) days following the date of the receipt of Special Notice within which to request a reconsideration or hearing. Said requests will be made by notice to the Chief Executive Officer. In the event the Practitioner does not request a reconsideration or hearing delineated herein, he or she will be deemed to have waived his or her right to such reconsideration and/or hearing, as applicable, and to have accepted the action involved and such action will thereupon become effective immediately upon final Board action.

SECTION 4. APPOINTMENT OF THE HEARING

When a hearing is timely requested and a right thereto exists, the Chief Executive Officer, acting for the Board and after considering the recommendations of the President of the Medical Staff and the Chair of the Board, will appoint a Hearing Panel which will be composed of not less than three (3) members. The Hearing Panel will be composed of: (1) members of the Active or Courtesy Staff, respectively, who will not have actively participated in the consideration of the matter involved at any previous level, or (2) of physicians or laypersons not connected with the Hospital, or (3) a combination of such persons. Such appointment will include designation of the Chair. Knowledge of the matter involved will not preclude a member of the Active or Courtesy Staff, respectively, from serving as a member of the Hearing Panel.

SECTION 5. TIME AND PLACE FOR HEARING

In the event Practitioner will be entitled to a hearing and timely requests a hearing pursuant to this section, the Chief Executive Officer will schedule the hearing and will give Special Notice to the person who requested the hearing of its time, place and date, which date will not be less than thirty (30) days after the date of the notice. The hearing will begin as soon as practicable, considering the schedules and availability of all concerned.

SECTION 6. EXCHANGE OF WITNESS AND EXHIBIT LISTS

Within ten (10) days following the date of the notice of the time, place and date of the hearing, each party will provide to the other a written list of the names and addresses of the witnesses that party intends to introduce (so far as is then reasonably known) and a list of the exhibits that party intends to introduce (so far as is then reasonably known) at that hearing. The witness and/or exhibit list must be supplemented, within a reasonable time, as the name and address of additional witnesses and additional exhibits become known. The witness and/or exhibit list of either party may, in the discretion of the hearing officer, be supplemented at any time during the course of the hearing.
SECTION 7. POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the time expressly permitted in this procedure may be requested by anyone but will be permitted only by the Hearing Panel or its Chair acting upon its behalf on a showing of good cause.

SECTION 8. HEARING PROCEDURE

A. PERSONAL PRESENCE MANDATORY • Under no circumstances will the hearing be conducted without the personal presence of the Practitioner requesting the hearing. Failure, without good cause, of the Practitioner requesting the hearing to appear and proceed at such a hearing, after appropriate notice, will be deemed to constitute voluntary acceptance of the recommendations or actions pending which will then become final and effective immediately. Postponements and extensions of time will be granted in accordance with Section 7 of this Fair Hearing Plan.

B. PRESENTATION • The Practitioner requesting the hearing will be entitled to be represented at the hearing by an attorney or a physician of his or her choice to examine witnesses and present his or her case. He or she will inform the Chief Executive Officer in writing of his or her choice within ten (10) days after he or she has been notified of the date set for the hearing. The Medical Executive Committee (if the hearing is an appeal from a recommendation of the Medical Executive Committee) or the Chief Executive Officer acting for the Board (if the hearing is commenced in response to Board action), will appoint a representative to present its recommendations and to examine witnesses. If the Practitioner exercises his or her right to be represented by an attorney at the hearing, the Medical Executive Committee or the Chief Executive Officer acting for the Board, whichever is appropriate, may use an attorney to present its case.

SECTION 9. THE HEARING OFFICER

The Chief Executive Officer may appoint a Hearing Officer who may be an attorney at law to preside at the hearing. Such Hearing Officer may be legal counsel to the Hospital. He or she must not act as a prosecuting officer, or as an advocate for the Board or the Medical Executive Committee but may act as provided in Section 10. He or she may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but he or she will not be entitled to vote on its recommendations.

SECTION 10. THE PRESIDING OFFICER

The Presiding Officer at the hearing will be the Hearing Officer or, if none has been appointed, the Chair of the Hearing Panel. The Presiding Officer will act to insure that all of the participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. He or she will determine the order of procedure throughout the hearing, and will have the authority and discretion, in accordance with this procedure, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which he or she may be advised by legal counsel to the Hospital. In all instances he or she will act in such a way that all information relevant to the continued appointment or clinical privileges of the Practitioner requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the
Hearing Officer is acting at all times for the Hospital in seeing to it that all relevant information is made available to the Hearing Panel for its deliberations.

SECTION 11. RECORD OF HEARING

The Hearing Panel will maintain a record of the hearing by one of the following methods: a court reporter present to make a record of the hearing or a tape recording capable of written transcription of the proceedings. The cost of such court reporter, if used, will be borne by the Hospital. The Practitioner requesting the hearing will be entitled to a copy of a written transcript of the proceedings upon the payment of any reasonable charges associated with the preparation thereof. The Hearing panel may, but will not be required to, order that oral evidence will be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

SECTION 12. RIGHTS OF BOTH SIDES

At a hearing both side will have the following rights: to call and examine witnesses, to introduce exhibits, to cross examine any witness on any matter relevant to the issues and to rebut any evidence whether presented by the opposing party or requested by the Hearing Panel. If the Practitioner requesting the hearing does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.

SECTION 13. ADMISSIBILITY OF EVIDENCE

The hearing will not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence will be admitted by the Presiding Officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Such evidence may include, but is not limited to, any material contained in the Hospital’s files regarding the Practitioner who requested the hearing and any and all applications, references and accompanying documents, so long as the Practitioner who requested the hearing is given the opportunity to comment on and, by other evidence, attempt to refute it. The Hearing Panel may interrogate the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate. In such cases, the Hearing Panel will give each party an opportunity to comment on any such additional evidence, and by other evidence, refute it.

SECTION 14. OFFICIAL NOTICE

The Presiding Officer will have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of the State of Idaho. Participants in the hearing will be informed of the matter to be officially noticed and such matters will be noted in the record of the hearing. Either party will have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonably additional time will be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
SECTION 15. MEMORANDUM OF POINTS AND AUTHORITIES

Each party will have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such memorandum to be filed following the close of the hearing. The Hearing Panel will have the power to specify the time limits within which any such memorandum of points and authorities is to be filed with the Hearing Panel.

SECTION 16. ADJOURNMENT AND CONCLUSION

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without Special Notice. Upon conclusion of all hearings and the submission of all memoranda of points and authorities, the hearing will be deemed finally adjourned. The Hearing Panel will thereupon conduct its deliberations and render a decision and accompanying report. The Hearing Panel may request the assistance of legal counsel to the Hospital in formulating and preparing its report.

SECTION 17. BURDEN OF PROOF

In all cases in which a hearing is conducted under this Fair Hearing section, the Medical Executive Committee will initially come forward with the evidence in support of its recommendation. Thereafter, the burden will shift to the Practitioner who requested the hearing to come forward with evidence in support of his or her appeal.

In all cases in which a hearing is conducted under this Fair Hearing section, the Hearing Panel will recommend against the Practitioner who requested the hearing unless it finds that said Practitioner has proved that the recommendation which prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

SECTION 18. BASIS OF DECISION

The decision of the Hearing Panel will be based upon permissible evidence produced at the hearing as described in Sections 13 of this Fair Hearing section.

SECTION 19. POST-HEARING PROCEDURE

A. RECOMMENDATION OF THE HEARING PANEL • Within twenty (20) days after final adjournment of the hearing, the Hearing Panel will render a recommendation, accompanied by a written report, which will contain a concise statement of the reasons justifying the recommendations made. At the same time, a copy of the report and recommendation will be delivered by certified mail, return receipt requested, to the Practitioner who requested the hearing.

B. DISPOSITION OF HEARING REPORT • If the hearing has been conducted by reason of an adverse recommendation by the Medical Executive Committee, the report of the Hearing Panel will be delivered to the Medical Executive Committee for whatever modification, if any, it wishes to make to its original recommendation. If the hearing has been conducted by reason of an action of the Board, the report of the Hearing Panel will be delivered to the Board.
SECTION 20. APPEAL

A. **TIME FOR APPEAL.** Within fifteen (15) days after the Practitioner is notified of either (1) a final recommendation adverse to him or her made by the Medical Executive Committee after a Hearing Panel review if he or she has requested one, or (2) an adverse recommendation from a Hearing Panel directly to the Board where a Hearing Panel reviewed an adverse recommendation of the Board following a favorable Medical Executive decision, he or she may request an appellate review. The request will be in writing and will be delivered to the Chief Executive Officer either in person or by certified mail and will include a brief statement of the grounds for appeal as provided in Section 20B below. If such appellate review is not requested within fifteen (15) days as provided herein, the affected individual will be deemed to have accepted the adverse recommendation involved and it will thereupon become final and immediately effective.

B. **GROUNDS FOR APPEAL.** The grounds for appeal from an adverse recommendation will be that:
   1. There was substantial failure on the part of the Medical Executive Committee or Hearing Panel to comply with the Hospital or Medical Staff Bylaws, including this Fair Hearing Plan, in the conduct of the hearings and recommendations based on the hearing so as to deny due process or a fair hearing; or
   2. The recommendation was made arbitrarily, capriciously or with prejudice; or
   3. The recommendation was not supported by the evidence.

C. **TIME, PLACE AND NOTICE.** Whenever an appeal is requested as set forth in the preceding sections, the Chair of the Board will, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The Board will cause the affected Practitioner to be given Special Notice of the time, place and date of the appellate review. The date of appellate review will not be less than twenty (20) days, nor more than forty (40) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a Practitioner who is under a suspension then in effect the appellate review will be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chair of the Board for good cause.

D. **NATURE OF APPELLATE REVIEW.** The Chair of the Board will appoint a Review Panel composed of not less than three (3) persons, either its own members, reputable persons outside the Hospital, or a combination of the two, to consider the record upon which the recommendation was made. The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Each party will have the right to present a written statement in support of his or her position on appeal, and in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument. The Review Panel may request the assistance of the legal counsel to the Hospital in formulating and preparing its report. The Review Panel will recommend final action to the Board. The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.

E. **FINAL DECISION OF THE BOARD.** Within thirty (30) days after the conclusion of the proceedings before the Review Panel, the board will render a final decision in writing and will deliver copies thereof to the affected Practitioner and to the Medical Executive Committee in person or by certified mail, return receipt requested.
F. **FURTHER REVIEW** • Except where the matter is referred for further action and recommendation in accordance with Section 20D, the final decision of the Board following the appeal will be effective immediately and will not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendations will be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board will in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

G. **RIGHT TO ONLY ONE APPEAL** • No Practitioner will be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the Medical Executive Committee or Hearing Panel, or a combination of acts of such bodies. However, nothing in this Fair Hearing Plan will restrict the right of an Applicant to reapply for appointment to the Medical Staff or restrict the right of any Medical Staff Member to apply for reappointment or an increase in clinical privileges after the expiration of two (2) years from the date of such Board decision unless the Board provides otherwise in its written discretion.

**SECTION 21. REPORTING**

The Chief Executive Officer, or his or her designee, will make appropriate reports to the Idaho State Board of Medicine and the National Practitioner Data Bank as required by law.

**SECTION 22. CONSTRUCTION WITH THE HEALTH CARE QUALITY IMPROVEMENT ACT**

This Fair Hearing Plan will be construed, and at all times will be consistent with, the Health Care Quality Improvement Act and its implementing regulations (HCQIA), and in the event of a conflict, HCQIA will control.
ARTICLE XVIII

AMENDMENT PROCEDURES

SECTION 1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff will have the responsibility to review the Medical Staff Bylaws and formulate recommendation to the Board, and amendments thereto, which will be effective when approved by the Board. Such responsibility will be exercised in good faith and in a reasonable, responsible and timely manner. Neither the Board nor the Medical Staff may unilaterally change the Medical Staff Bylaws.

SECTION 2. METHODS OF BYLAWS ADOPTION AND AMENDMENT

A. PROPOSED AMENDMENTS • Proposed Bylaws amendments may be originated by the Medical Executive Committee, Bylaws Committee, department, a committee, or by an active member of the medical staff. Except for those amendments proposed by the Medical Executive Committee, all proposed amendments will be submitted to the Bylaws Committee. An amendment, initiated and approved by the Medical Executive Committee, will be subsequently reviewed by the Bylaws Committee, as an information item. (rev 4/07)

1. The Medical Executive Committee will vote on proposed amendments at the next regular meeting, or at a special meeting called for such purpose. Following a favorable vote by the Medical Executive Committee, each active medical staff member will be eligible to vote on the proposed amendment by returning a printed ballot, distributed at least fourteen (14) working days prior to the deadline for receipt of the ballot. An affirmative vote may be cast by marking the ballot "yes" and a negative vote by marking the ballot “no” and returning it to the Office of Medical Affairs. To be adopted, such amendments must receive a majority of the votes cast by the active medical staff.

2. If the Medical Executive Committee does not vote favorably on a proposed amendment, the issue may be presented to a special meeting of the medical staff called for the purpose of voting on the issue. To be adopted, such amendments must receive a majority of the votes cast by the active medical staff.

3. Any amendment adopted by the Medical Executive Committee or the medical staff will become effective only when the Board approves it.

SECTION 3. OTHER MEDICAL STAFF POLICIES AND PROCEDURES

The Medical Executive Committee will recommend to the Board an Organization Manual, Medical Staff Policy and Plans, Allied Health Plan (or subsequently designated documents) and such additional policies and procedures as deemed necessary to further define the general principles contained in these Bylaws. Upon adoption by the Board, these documents will be incorporated by reference and become supplemental to the Bylaws.

The Medical Staff Policy and Plans, Organization Manual, Allied Health Plan (or subsequently designated documents) and other medical staff policies and procedures may be amended, repealed or added to by vote of the Medical Executive Committee at any regular or special
meeting, and are made available to all members of the Medical Executive Committee seven (7) days before being voted on by the Medical Executive Committee. Any change to the Bylaws will be subject to a vote of the Medical Staff in a manner consistent with Article VXIII, section 2, paragraph A of the Bylaws.

Any proposed change or amendment to the Policy and Plans, Organizational Manual and Allied Health Plan will be posted in a conspicuous place and communicated to the Medical Staff via electronic mail prior to adoption. Once approved, any such change or amendment will be communicated to the Medical Staff by posting in a conspicuous place and via electronic mail.

**Urgent Approval Procedures:** From time to time it may be necessary for an urgent amendment to the Policy and Plans, Organizational Manual of Allied Health Plan, necessary to comply with law or regulation without prior notification of the medical staff. In such a case the Medical Executive Committee can make the necessary changes. Approval for this purpose is delegated to the Medical Executive Committee by voting members of the organized medical staff. Amendment and approval of any such rule of regulations is provisional and must be communicated for confirmation. The following procedure will be used to make urgent amendments.

a) The medical staff will be immediately notified by the Medical Executive Committee that an amendment was made.
b) The medical staff has the opportunity for retrospective review of and comment on the provisional amendment.
c) If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands.
d) If there is a conflict to the amendment the medical staff may appeal using those processes outlined in Article I, Section 8, C, Medical Staff Member and Practitioner Rights and Conflict Resolution of these Bylaws.
e) If necessary, a revised amendment is then submitted to the Board for final approval.

Changes in all Medical Staff documents will only be effective when approved by the Board.
These Bylaws are adopted and made effective February 10, 2021, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each and every member of the Medical Staff will be taken under and pursuant to the requirements of these Bylaws.

APPROVED by the Medical Staff the 9th day of February 2022.

Williams Edwards, MD
President of the Medical Staff

APPROVED by the Board of Trustees the 22nd day of February 2022.

David McFadyen
President, Saint Alphonsus Regional Medical Center
1. **ADMISSION** is a clinical decision made by a Physician and includes “in-patient,” “outpatient,” and emergency room admissions to the Hospital.

2. **ALLIED HEALTH PROFESSIONAL** is an individual, not a member of the Medical Staff, who is trained in some aspect of the evaluation or treatment of human illness and who is allowed, after the approval of the Credentials Committee, Medical Executive Committee, Chief Executive Officer and the Board to provide specified services to patients as defined in the Allied Health Plan.

3. **ACTIVE AMBULATORY PROVIDER STAFF** means any qualified provider who practices in an ambulatory setting, who, after the approval of the Credentials Committee, Medical Executive Committee, Chief Executive Officer and the Board, provides specified services to patients in an ambulatory setting.

4. **APPLICANT** means any qualified physician, dentist or independent practitioner who has fully completed an application for appointment or reappointment to the Medical Staff of the Hospital, who has paid all applicable application fees, and whose application has been accepted by the Hospital as complete and appropriate.

5. **ATTENDING PHYSICIAN** for any particular patient means the medical staff member who has responsibility for providing and supervising care for such patient. The medical staff member who admits the patient to the Hospital will be the attending physician for such patient until such time as the responsibility for care of the patient is assigned to and accepted by another member of the medical staff.

6. **BOARD OF TRUSTEES** or **BOARD** means the Board of Trustees of Saint Alphonsus Regional Medical Center which has the overall responsibility for the conduct of the affairs of the Hospital including those of the medical staff by virtue of the authority vested in it by law and by its Articles and Bylaws.

7. **CHIEF EXECUTIVE OFFICER** or **CEO** means the Administrator or President of the Hospital or his or her designees.

8. **CLINICAL PRIVILEGES** or **PRIVILEGES** means permission granted to a physician, dentist, or independent practitioner to provide medical or other patient care services in the Hospital, within well-defined limits, based on the individual’s professional license, experience, competence, judgment and other criteria set forth in these Bylaws.

9. **DENTIST** means an individual with a degree of doctor of dental surgery or doctor of dental medicine and who is fully licensed in Idaho to practice dentistry in all its phases.

10. **EX OFFICIO** means service as a member of a body by virtue of an office or committee position held and, unless otherwise expressly provided, means without voting rights.

11. **FELLOW** means a physician who has completed a residency and is undertaking further post-
graduate work.

12. **HOSPITAL** means Saint Alphonsus Regional Medical Center, Inc.

13. **HOSPITALIST** means a physician who serves as physician–of–record for inpatients, in lieu of the primary care provider, returning the patients back to the care of their primary care provider at time of discharge.

14. **INDEPENDENT PRACTITIONER** means any individual who is permitted by law and who is also permitted by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and in accordance with individually granted clinical privileges. For the purposes of these Bylaws, Independent Practitioner is limited to podiatrists and psychologists.

15. **MEDICAL STAFF** is defined as all physicians, dentists, and independent practitioners holding licenses who are privileged to attend patients at the Hospital.

16. **MEDICAL STAFF MEMBER or MEMBER** means a physician, dentist or independent practitioner, who possesses Medical Staff Membership.

17. **PHYSICIAN** means an individual with a doctor of medicine (MD) or a doctor of osteopathy (DO) degree who is fully licensed in Idaho to practice medicine in all its phases. The term does not include dentists, independent practitioners, allied health professionals or medical students.

18. **PODIATRIST** means an individual with a degree in podiatry who is fully licensed in Idaho to practice podiatry in all its phases.

19. **PRACTITIONER** as used in these Bylaws means, unless otherwise expressly limited, any physician, dentist or independent practitioner who is applying for Medical Staff membership and/or clinical privileges at the Hospital or who is a Medical Staff Member and/or who exercises clinical privileges in the Hospital.

20. **PREROGATIVE** means a participatory right granted, by virtue of medical staff status or otherwise, to a member, and may be exercised subject to the conditions imposed in these Bylaws, Organization Manual and Policy & Plans and in other Hospital and medical staff policies or procedures.

21. **PRESIDENT** means the physician holding the Medical Staff Office of President of the Medical Staff.

22. **PSYCHOLOGIST** means an individual with a degree in psychology who is fully licensed in Idaho to practice psychology in all its phases.

23. **RESIDENT** means an individual with a medical degree undergoing specialized training under the supervision of a Medical Staff Member.

24. **SPECIAL NOTICE** means written notification given either by personal delivery or by certified or registered mail, return receipt requested. Refusal to accept Special Notice sent by registered mail will constitute receipt of such notice.
25. **TELEMEDICINE** means the use to telecommunications to provide medical information and services.

27. **VICE-PRESIDENT, CHIEF QUALITY AND PATIENT SAFETY OFFICER** means the administrative physician Vice-President responsible for quality and patient safety.