# MEDICAL STAFF BYLAWS

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MEDICAL STAFF BYLAWS OF
SAINT ALPHONSUS MEDICAL CENTER - NAMPA

PURPOSE(S) OF THE BYLAWS:

These bylaws are adopted in order to provide for the organization of the medical staff of Saint Alphonsus Medical Center - Nampa, Inc. and to provide a framework for self-governance in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the board of directors, and relations with applicants to the members of the medical staff. The organized medical staff both enforces and complies with these medical staff bylaws.

These bylaws recognize that the organized medical staff has the authority to establish and maintain patient care standards, including full participation in the development of hospital-wide policy, involving the oversight of care, treatment, and services provided by members and others in the hospital. The medical staff is also responsible for and involved with all aspects of delivery of health care within the hospital including, but not limited to, the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these bylaws and the functions of credentialing and peer review.

These bylaws acknowledge that the provision of quality medical care in the hospital depends on the mutual accountability, interdependence, and responsibility of the medical staff and the hospital governing board for the proper performance of their respective obligation.
DEFINITIONS

The following definitions shall apply to terms used in these Bylaws, unless otherwise defined herein:

BOARD means the Saint Alphonsus Medical Center - Nampa, Inc; "Board" means the Saint Alphonsus Medical Center – Nampa, Inc. Board, a subsidiary of Saint Alphonsus Health System, Inc. (SAHS). The Board has delegated certain responsibilities for the oversight of the Medical Staff for responsibility, authority and accountability of the affairs of the Medical Staff, including its credentialing and peer review activities, to the SAHS Quality Committee.

CHIEF EXECUTIVE OFFICER means the President of the Hospital or his designee;

DENTIST means a licensed dentist and a doctor of dental medicine D.D.S. or D.M.D.;

EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board";

HOSPITAL means Saint Alphonsus Medical Center - Nampa, Inc., Nampa, Idaho, and any facility at which services are provided which are charged using the Medicare Provider Number for Saint Alphonsus Medical Center - Nampa, Inc., Nampa, Idaho.

MEDICAL STAFF or STAFF means all physicians, oral and maxillofacial surgeons, dentists and podiatrists who are given privileges to treat patients in the Hospital or in an outpatient department of the Hospital;

MEDICAL STAFF YEAR means January 1 to December 31;

ORAL AND MAXILLOFACIAL SURGEON means a licensed dentist who has successfully completed a post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education;

PODIATRIST means a licensed podiatrist and a doctor of podiatric medicine D.P.M;

PRESIDENT means President of the Medical Staff;

PHYSICIAN means an individual with an M.D., D.O., D.D.S., D.M.D., or DPM degree. PHYSICIAN also means an individual with an MBBS or similar foreign medical school degree and a valid certificate from the Educational Commission for Foreign Medical Graduates ("ECFMG") and the successful completion of an Accreditation Council for Graduate Medical Education ("ACGME") or American Osteopathic Association (AOA) recognized residency training program.

PEER means an appropriate practitioner in the same professional discipline as the applicant – for example, physician, dentist, podiatrist.

Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender.
ARTICLE I

APPOINTMENT TO THE MEDICAL STAFF

ARTICLE I-PART A: QUALIFICATIONS FOR APPOINTMENT AND CONTINUED MEMBERSHIP

SECTION 1. NATURE OF APPOINTMENT

Appointment to the Medical Staff is a privilege, which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws. All individuals practicing medicine, dentistry and podiatry in the Hospital, unless excepted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff.

SECTION 2. GENERAL QUALIFICATIONS

Only physicians, included in definition of physician, who meet the following shall be qualified for appointment to the Medical Staff:

A. are currently licensed to practice in this state. The Medical Staff Office shall conduct primary source licensure verification at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration.
B. possess current, valid federal and state narcotics certificates, with the exception of pathologists and radiologists who may not require this for their practice;
C. are located close enough to provide timely care for their patients;
D. possess current, valid professional liability insurance coverage in amounts satisfactory to the Hospital;
E. can provide at initial appointment documentation of identity, by either a copy of current driver’s license with photograph or current passport, to ensure that they are the individual identified in credentialing documents;
F. can safely and competently exercise the clinical privileges requested with or without reasonable accommodation;
G. can provide sufficient current evidence of active participation in acceptable peer review, professional practice review and other quality improvement activities by an organization(s) that currently privileges the applicant (if available); and
H. can document their background, experience, training and demonstrated current competence, their adherence to the ethics of their profession, their good reputation and character (character is intended to include the applicant’s mental and emotional stability) and their ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them in the Hospital will receive appropriate care and that the Hospital and its Medical Staff will be able to operate in an orderly manner;
I. can establish to the satisfaction of Credentials and Medical Executive Committees that he or she is Board Certified in the specialty(s) and subspecialty(s) in which Clinical Privileges are
requested or, if the applicant completed his training within the last five years, is Board Eligible in those (sub)specialty(s). Members must be Board Certified within the maximum time that the member's specialty board allows. Medical Staff appointment shall not be determined solely on the basis of board certification. For purposes of this section, the physician's "area of specialty" in which the physician is required to be board certified or in which the physician may become board certified may be determined by the department to which the physician is applying for privileges, subject to approval by the Credentials Committee and Medical Executive Committee.

Members who joined the Medical Staff prior to February 1, 2005 and general Dentists are not required to be Board Certified or Board Eligible.

An approved board is one certified either by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Foot and Ankle Surgery, or the American Board of Oral and Maxillofacial Surgery.

Until a certifying board for Dentists, acceptable to the Board of Directors, comes into existence, Dentists shall be exempt from this board certification and recertification requirement.

All physicians shall continuously maintain such board certification thereafter.

SECTION 3. NO ENTITLEMENT

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that:

A. he is licensed to practice any profession in this or any other state;
B. he is a member of any particular professional organization or society;
C. he has successfully completed a fellowship;
D. he had in the past, or currently has, Medical Staff appointment or privileges at another hospital;
E. he is certified or eligible for certification by any specialty board;
F. he resides in the service area of the Hospital;
G. he is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, provider network or other entity; or
H. he is employed in an administrative or other position with the hospital.

SECTION 4. NO DISCRIMINATION

No individual shall be denied appointment on the basis of religion, age, sex, race, creed, color, national origin or disability.

SECTION 5. ETHICAL AND RELIGIOUS DIRECTIVES

All Medical Staff appointees exercising clinical privileges in the Hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the
National Conference of Catholic Bishops. No activity prohibited by said Directives shall be engaged in by any Medical Staff appointee or other person exercising clinical privileges in the Hospital.

A copy of The Ethical and Religious Directives for Catholic Health Care Services is located in the physician's lounge or can be obtained through the Medical Staff Office.

SECTION 6. MEDICARE EXCLUSIONS

No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff, Medical Associate Staff or APP membership.

SECTION 7. ADHERENCE TO CORPORATE RESPONSIBILITY PROGRAM

All Medical Staff appointees shall abide by the Corporate Responsibility Program, including, without limitation, the Trinity Health Organizational Integrity Program and any related education and training requirements. Failure to do so shall be grounds for corrective action.

SECTION 8. TERM OF APPOINTMENT

No appointment or reappointment to the Medical Staff nor initial granting or renewal of clinical privileges shall be for a period exceeding two (2) years. Each appointment shall state the date on which it terminates. Recommendations for a reappointment period of less than two (2) years may be made by the Department chairman, Credentials Committee, and/or Medical Executive Committee. A reappointment recommendation of less than two (2) years is not an action which constitutes grounds for a fair hearing or an appeal under the Corrective Action Section of these Bylaws and is not reportable to the National Practitioner Data Bank.

SECTION 9. PEER REVIEW CONFIDENTIALITY

All Medical Staff appointees shall maintain the confidentiality of information received, obtained, discussed and generated by hospital and Medical Staff quality assurance and improvement, and peer review activities in accordance with these bylaws and in accordance with Idaho Code Section 39-1392 through 39-1392f.

SECTION 10. ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)

As a condition of appointment and reappointment, all Medical Staff and Practitioners with clinical privileges at the Hospital, effective as of the date of appointment, shall become a participant in an Organized Health Care Arrangement (OHCA) with Saint Alphonsus Medical Center - Nampa, Inc. Each member shall comply with Saint Alphonsus Medical Center-Nampa, Inc.’s policies and procedures related to the use or disclosure of individually identifiable health information as a participant of the OHCA.
SECTION 11. RIGHTS AND DUTIES OF APPOINTEES

Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been recommended by the Credentials Committee and Executive Committee and approved by the Board, and shall require that each appointee assume such reasonable duties and responsibilities as the Medical Staff shall require.

ARTICLE I- PART B: CONDITIONS OF APPOINTMENT

SECTION 1. PROVISIONAL PERIOD

All initial appointments to the Medical Staff shall be provisional until sufficient performance data is available to evaluate clinical competence. During the provisional period, A proctor shall be assigned to evaluate the individual's competence to exercise the clinical privileges granted and general conduct in the Hospital. This evaluation shall be reviewed by the chair of his or her department and include Focused Professional Practice Evaluation (FPPE) criteria for privileges requested. Continued appointment and staff status reclassification to a non-provisional status shall be conditioned upon an evaluation of the FPPE by the proctoring physician or department chair. Affiliate Staff Members are exempted from this provision.

SECTION 2. FOCUSED PROFESSIONAL PRACTICE EVALUATION

Focused Professional Practice Evaluation (FPPE) shall be conducted to assist the Medical Staff in assessing current clinical competence of Medical Staff members at Saint Alphonsus Medical Center- Nampa, Inc. under the following circumstances:

1. Initially requested privileges of all new Medical Staff members; and
2. Current Medical Staff members seeking additional privileges or privileges to perform new or rarely performed procedures prior to granting of the privilege to independently perform requested procedures; and
3. When questions arise regarding a practitioner's professional performance that may affect the provision of safe, high quality patient care.

The complete FPPE policy can be found in the Policy and Plans, Chapter X, Section 1.

SECTION 3. 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 has had extended periods of absence due to maternity/paternity) may be required to enter an intensified provisional period. During an intensified provisional period, the Practitioner shall 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 shall 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. 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 shall accompany the application and must be approved by the department chair and Credentials Committee. Successful completion of the intensified provisional period shall be considered independent of the provisional period outlined in Section 1 above.

All appointments to the Medical Staff shall be made by the Board, and shall be to one of the following categories of Staff. All appointees shall be appointed to a specific department but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and approved by the Board.

The Medical Staff categories shall consist of Active, Courtesy, Affiliate, Ambulatory, Locum Tenens, and Honorary Staff.
ARTICLE II

CATEGORIES OF THE MEDICAL STAFF

ARTICLE II – PART A: ACTIVE STAFF

SECTION 1. QUALIFICATIONS

The Active Staff shall consist of those practitioners, who meet the criteria for appointment contained in Article VII of these Bylaws.

With the exception of hospital-based physicians, members of the Active Staff must have more than twelve (12) inpatient admissions, consultations and/or procedures and/or outpatient procedures per year.

If the Active Staff Physician has twelve (12) or fewer inpatient admissions, consultations and/or procedures and/or outpatient procedures during a year, they shall no longer meet the Qualifications for Active Staff and shall be automatically placed on the Courtesy Staff or Affiliate Staff (depending on activity) effective the 1st day of the month following notification of the physician, if he or she meets the Qualifications for Courtesy Staff or Affiliate Staff category.

Active Staff includes all hospital-based physicians including Anesthesiologists, Pathologists, Radiologists, Hospitalists and Emergency Department Physicians.

SECTION 2. FUNCTIONS AND RESPONSIBILITIES

Each appointee to the Active Staff agrees to assume all the functions and responsibilities of appointment to the Active Staff, including, when appropriate:

A. admit and treat patients in the Hospital in accordance with the clinical privileges granted;

B. vote, hold office, serve on Medical Staff committees, and serve as chair of such committees;

C. care for unassigned patients and accept reasonable emergency call in compliance with EMTALA regulations (with the exception of medical staff members who are sixty (60) years of age or greater or who have been on the Active Staff for a continuous period of twenty-five (25) years, who will have the option of providing emergency call, if approved by their department). The on-call requirements are set forth in the Policy and Plans attached hereto;

D. provide consultation(s);

E. participate in teaching assignments;

F. participate in performance improvement and monitoring activities, including the evaluation of new appointees;

G. attend Medical Staff meetings in accordance with Article IV of these Bylaws;

H. be located within a sufficiently close distance to the Hospital to provide continuous and
timely care for their patients;
I. pay dues and assessments; and
J. participate in continuing medical education.

ARTICLE II – PART B: COURTESY STAFF

SECTION 1. QUALIFICATIONS

The Courtesy Staff shall consist of practitioners, who meet the criteria for appointment contained in the Article VI of these Bylaws. Members of the Courtesy Staff must have at least six (6) but no more than twelve (12) inpatient admissions, consultations and/or procedures and/or outpatient procedures per year or must be a member, in good standing, at a Joint Commission or CMS accredited facility and provide the Hospital with data of activity at that facility, as well as peer review and/or performance improvement data from that facility, or his or her office practice, upon request.

If the Courtesy Staff Physician does not meet the requirements of at least six (6) but no more than twelve (12) inpatient admissions, consultations and/or procedures and/or outpatient procedures during a year, they shall no longer meet the Qualifications for Courtesy Staff and shall be automatically placed on the Active Staff or Affiliate Staff (depending on activity) effective the 1st day of the month following notification of the physician, if he or she meets the Qualifications for Active Staff or Affiliate Staff category.

If the Courtesy Staff Physician has less than six (6) inpatient admissions, consultations and/or procedures and/or outpatient procedures during a calendar year or if they are not a member, in good standing, at a Joint Commission or CMS accredited facility and cannot provide the Hospital with any of the data outlined in Section 1 (a) above, they shall no longer meet the Qualifications for Courtesy Staff and shall be automatically placed on the Affiliate Staff the 1st day of the month following notification of the physician, if he or she meets the Qualifications for Affiliate Staff.

SECTION 2. FUNCTIONS AND RESPONSIBILITIES

Courtesy Staff appointees:

A. shall have no staff committee responsibilities, but are encouraged to attend staff and department meetings;
B. may not vote or hold office;
C. must be located within a sufficiently close distance to the Hospital to provide continuous and timely care for their patients;
D. must pay dues and assessments; and
E. may participate in continuing medical education.
ARTICLE II – PART C. – AFFILIATE STAFF

SECTION 1. QUALIFICATIONS

The Affiliate Staff shall consist of those physicians, dentists, or podiatrists who desire to be associated with, but who do not intend to establish a practice, at Saint Alphonsus Medical Center – Nampa, Inc. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education endeavors, and to allow such individuals to refer patients to other members of the staff for admission, evaluation, and/or care and treatment;

Individuals requesting appointment to the Affiliate Staff must submit an application as prescribed by the Medical Staff Bylaws. They shall not, however, be required to satisfy the qualifications set forth in Article I, Part A, Section 2.

SECTION 2. FUNCTIONS AND RESPONSIBILITIES

A. Appointees to this category must:
   1. possess current valid license to practice medicine in this state;
   2. possess current, valid federal and state narcotics certificate, with the exception of pathologists and radiologists who may not require this for their practice;
   3. possess current, valid professional liability insurance coverage in amounts satisfactory to the Hospital;

B. Appointees to this category:
   1. may attend meetings of the medical staff, departments and committees (all without vote);
   2. may not vote;
   3. may not hold office;
   4. may attend educational programs of the medical staff
   5. may refer patients to members of the Medical Staff for admission and/or treatment;
   6. may visit their patients when hospitalized and review their medical records, but may not write orders or make medical record entries or actively participate in the provision or management of care to patients;
   7. are permitted to use the hospital’s diagnostic facilities;
   8. may order infusions/transfusions related to their specialty provided they have a prearranged proxy, identified in the order set, to address any complications or admit the patient if needed;
   9. may not be granted clinical privileges, with the exception of surgical assisting privileges if granted by the Board, and may not admit or treat patients at the hospital; and
   10. shall be required to pay application fees and medical staff dues.
   11. shall not be required to be board certified
   12. shall not be required to submit proof of CME credit within their appointment period.

Appointment as an Affiliate Staff member is a courtesy only, which may be terminated by the Board (or its designee) upon recommendation of the Credentials Committee and Medical Executive Committee, without rights to the hearing or appeal procedures set forth in Article X and Article XI below.
ARTICLE II – PART D: AMBULATORY STAFF

SECTION 1. QUALIFICATIONS

The Ambulatory Staff shall consist of those Physicians who meet the criteria for appointment contained in Article III & IV of these Bylaws. The primary purpose of the Ambulatory Staff is to accommodate a Physician who desires to limit his or her practice to outpatient departments of the Hospital and will not have privileges to admit or treat inpatients.

Members of the Ambulatory Staff shall treat or perform procedures on or otherwise be involved in the care of at least six (6) outpatients per year.

Ambulatory Staff shall provide the Hospital with peer review and/or performance improvement data from another institution at which the Physician has privileges or from the Physician’s office practice, upon request.

SECTION 2. FUNCTIONS AND RESPONSIBILITIES

Ambulatory Staff appointees:

A. shall exercise such clinical privileges at the Hospital outpatient departments as are granted by the Board.
B. shall have no staff committee responsibilities nor shall Ambulatory Staff be obligated to participate in medical staff meetings, but are encouraged to attend staff and department meetings;
C. shall not be obligated to comply with Article II – Part A: Active Staff, Section 2C; only if able to document that he or she provides emergency call coverage as a member of the Medical Staff at a hospital. Further, if at any time an Ambulatory Staff appointee’s emergency call obligations at a hospital cease, the appointee must notify the Hospital and thereafter must comply with Article II – Part A: Active Staff, Section 2C;
D. may not vote or hold office;
E. must pay dues and assessments;
F. may participate in continuing medical education; and
G. may order infusions/transfusions related to their specialty provided they have a prearranged proxy, identified in the order set, to address any complications or admit the patient if needed.

ARTICLE II – PART E: 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 on a temporary basis.

SECTION 1. QUALIFICATIONS

Locum Tenens Staff must meet the qualifications for appointment and continued membership in Article I, Part A of these Bylaws.
SECTION 2. FUNCTIONS AND RESPONSIBILITIES

Admit patients, consult on patients and exercise such clinical privileges as are granted by the Board.

ARTICLE II – PART F: 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 education activities, and may be appointed to committees.
OFFICERS

SECTION 1. IDENTIFICATION OF OFFICERS

The officers of the Medical Staff shall be the President, President-Elect and Secretary/Treasurer.

The officers must:

A. be members in good standing of the Active Staff at the time of their nomination and election;
B. have no pending adverse recommendations concerning Staff appointment or clinical privileges;
C. have demonstrated interest in maintaining quality medical care at the Hospital;
D. not be presently serving as a Medical Staff or corporate officer, department or committee chairman at another hospital, and shall not so serve during their term of office;
E. have constructively participated in Medical Staff affairs for a minimum of one (1) year;
F. be willing to discharge faithfully the duties and responsibilities of the position to which they are elected or appointed;
G. be knowledgeable concerning the duties of their office;
H. possess written and oral communication skills;
I. possess and have demonstrated an ability for harmonious, professional interpersonal relationships; and
J. identify employment or other contractual arrangements with hospitals or health care systems not affiliated with this Hospital prior to appointment.

All Medical Staff officers must possess at least the above qualifications and maintain them during their term of office. Failure to do so shall automatically create a vacancy in the office involved.

SECTION 2. THE PRESIDENT

The President shall:

A. act on behalf of the Board as the chief medical officer of the Hospital, in coordination and cooperation with the Chief Executive Officer, in matters of mutual concern involving the Hospital;
B. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
C. appoint committee chairmen and members to all standing and special Medical Staff committees except the Executive Committee;
D. serve as a voting member and chairman of the Executive Committee and as an ex-officio member of all Medical Staff committees other than the Executive Committee, without vote;
E. represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the Staff to the Board and to the Chief Executive Officer;
F. provide day-to-day liaison on medical matters with the Vice President of Medical Affairs, Chief Executive Officer and the Board;
G. receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care;
H. cause to be kept accurate and complete minutes of all Executive Committee and Medical Staff meetings;
I. cause attendance to be recorded at Medical Staff and committee meetings;
J. serve as an ex-officio member of the Board without vote; and
K. attend to all correspondence, submit such reports and perform such other duties as ordinarily pertain to his office.

SECTION 3. PRESIDENT-ELECT

The President-Elect shall:

A. assume all the duties and have the authority of the President in the event of the President's temporary inability to perform due to illness, being out of the community or being unavailable for any other reason;
B. be a member of the Executive Committee;
C. automatically succeed the President at the conclusion of the President's term of office and when the President fails to serve for any reason; and
D. perform such duties as are assigned to him by the President.

Should both the President and the President-Elect be unavailable in an emergency, the authority and duties of the President will be temporarily assumed by the Chairman of the Department of Medicine, Chairman of the Department of Surgery or Chairman of the Department of Obstetrics, in that order.

SECTION 4. SECRETARY/TREASURER

The Secretary/Treasurer shall:

A. be a voting member-at-large of the Executive Committee;
B. cause to be kept accurate and complete minutes of all Executive Committee and Medical Staff meetings;
C. call Medical Staff meetings on order of the President and record attendance;
D. attend to all correspondence and perform such other duties as ordinarily pertain to his office;
E. keep accurate records of all monies collected and disbursed and submit an annual report thereon to the staff; and
F. submit such other reports and perform such other duties as directed by the President from time to time.
SECTION 5. ELECTION OF OFFICERS

At least three (3) months before the scheduled date of the next Medical Staff election, the President shall appoint a Nominating Committee consisting of three (3) Active Staff appointees. The Nominating Committee shall prepare a slate of nominees for each office to be filled at that election.

Nominations for officers of the Medical Staff whose terms have expired shall be presented by the Nominating Committee and by the floor, if any, at the annual meeting. The candidates who receive a majority vote of those Medical Staff appointees eligible to vote and present at the meeting at the time the vote is taken shall be elected. The vote shall be by written secret ballot. Each officer shall then serve from the start of the next Medical Staff Year for a term of two (2) years or until his successor has been elected.

In any election, if there are three (3) or more candidates for an office and no candidate receives a majority vote, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until majority vote is obtained by one (1) candidate.

SECTION 6. REMOVAL OF OFFICERS

A. Reasons for Removal:
   Officers may be removed from office for reasons including the following:

1. Failure to conduct those responsibilities assigned within these Bylaws and 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 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 shall 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 shall be presented to the President Elect or Secretary/Treasurer who shall present it to the Medical Executive Committee at its next scheduled meeting. The Medical Executive Committee shall 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.

SECTION 7. VACANCIES IN OFFICE

If there is a vacancy in the office of the President prior to the expiration of the President's term, the President-Elect shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in the office of the President-Elect, the Executive Committee shall appoint another Active Staff appointee to serve out the remainder of the unexpired term.
ARTICLE IV

MEETINGS

SECTION 1. ANNUAL STAFF MEETING

The Medical Staff shall, at least ten (10) days before the end of the Staff year, hold a meeting at which officers for the ensuing year shall be elected.

SECTION 2. REGULAR STAFF MEETINGS

The Medical Staff may meet quarterly or as often as necessary for the purpose of reviewing and evaluating departmental and committee reports and recommendations, and to act on any other matters placed on the agenda by the President. One of these meetings shall be the annual meeting.

SECTION 3. SPECIAL STAFF MEETINGS

Special meetings of the Medical Staff may be called at any time by the Board, the Chief Executive Officer, the President, a majority of the Executive Committee or a petition signed by no less than one-fourth (1/4) of the voting Staff. In the event that it is necessary for the Staff to act on a question without being able to meet, the voting Staff may be presented with the question by mail and their votes returned to the President by mail. Such a vote shall be valid so long as the question is voted on by a majority of the Staff eligible to vote.

A special meeting of any committee or department may be called by or at the request of the chairman or the President, or by a petition signed by not less than one-fourth (1/4) of the members of the department or committee.

In the event that it is necessary for a committee or department to act on a question without being able to meet, the voting members may be presented with the question, in person, by mail, or by electronic mail and their vote returned to the chairman of the committee or department. Such a vote shall be binding as long as the question is voted on by a majority of the committee or department members eligible to vote.

SECTION 4. QUORUM

The eligible voting Staff members present shall constitute a quorum for any regular or special meeting of the Medical Staff.

The presence of not less than two (2) of the total membership of the committee or department eligible to vote at any regular or special meeting shall constitute a quorum for all actions.
SECTION 5. AGENDA

The agenda at any regular Medical Staff meeting shall be at the discretion of the President and may include:

A. call to order;
B. acceptance of the minutes of the last regular meeting and all intervening special meetings;
C. report from the Chief Executive Officer;
D. report of the Executive Committee;
E. committee reports;
F. discussion and recommendations for improvement of the professional work of the Medical Staff and the Hospital;
G. old business;
H. new business; and
I. adjournment.

The agenda at special meetings shall be:
A. reading of the notice calling the meeting;
B. transaction of business for which the meeting was called; and
C. adjournment.

SECTION 6. MINUTES

Minutes of each meeting of each committee and each department shall be prepared and shall include a record of the attendance of members, of the recommendations made and of the votes taken on each matter. The minutes shall be reviewed by the presiding officer and copies thereof shall be forwarded to the Executive Committee and to the Chief Executive Officer unless otherwise specified for certain committees elsewhere in these Bylaws. Each committee and each department shall maintain a permanent file of the minutes of each of its meetings.

SECTION 7. DEPARTMENT MEETINGS

All departments shall meet at least quarterly, or as often as necessary, at a time set by the chairman of the department, to conduct business and participate in monitoring and evaluation activities, including identification of important aspects of care, the identification of indicators to be used to monitor the quality of care, and the evaluation of the care provided. The agenda for the meeting and its general conduct shall be set by the chairman.

SECTION 8. COMMITTEE MEETINGS

All committees shall meet quarterly, unless otherwise specified, at a time set by the chairman of the committee. The agenda of the meeting and its general conduct shall be set by the chairman.

SECTION 9. POSTING NOTICE OF MEETINGS

Notice of all meetings of the Medical Staff and regular meetings of departments and committees shall be posted on the Medical Staff bulletin board at least five (5) days in advance of such
meetings. Such posting shall be deemed to constitute actual notice to the persons concerned.

SECTION 10. ATTENDANCE REQUIREMENTS

All Active Staff appointees are encouraged to attend their department and committee meetings each year. While attendance is not mandatory, it is highly recommended. Each department and committee may develop and enforce its own meeting attendance requirements.

SECTION 11. RULES OF ORDER

Wherever or whenever they do not conflict with these Bylaws, the currently revised Robert's Rules of Order shall govern all meetings and elections.

SECTION 12. VOTING

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one (1) vote.

SECTION 13. ACTION

Except as otherwise specified, the majority vote of the Medical Staff members present at a meeting who are eligible to vote shall constitute the action of the group if a quorum has been met.

SECTION 14. MEDICAL STAFF OFFICE REPRESENTATIVES

Medical Staff Office (MSO) Representatives may attend all medical staff meetings as necessary, without vote. MSO Representatives attend meetings to provide expertise, assist in running the meeting and other functions needed.
ARTICLE V

GENERAL PROVISIONS

SECTION 1. REQUIREMENTS FOR COMPLETING AND DOCUMENTING MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS

A history and physical examination is required for all patients and shall be dictated, received from the physician’s office or legibly hand-written in the record within twenty-four (24) hours after admission or prior to an operative or invasive procedure, whichever occurs first. History and physicals from the physician’s office must have been done within 30 days prior to admission or outpatient services (see Updates to The Patient’s Condition below). When it does not meet the 30-day rule, a new history and physical must be dictated or legibly written. A qualified licensed practitioner, who is a member of the Medical Staff or the Advanced Practice Professional Staff, must perform the history and physical. Requirements for oral and maxillofacial surgeons, dentists and podiatrists completing and documenting medical histories and physical examinations are detailed under Article VI, PART C Section 2. A history and physical performed by an authorized APP will be counter-signed by their supervising or sponsoring physician, or their designee. If a licensed independent practitioner is not a member of the Medical Staff, the history and physical will be reviewed and signed by a physician on the staff.

Updates to the Patient’s Condition: Updates are to be recorded within 24 hours after admission in the record. For surgical and high-risk procedures, there must be an update to the patient’s condition recorded prior to the start of the procedure (anesthesia evaluation, progress notes, written on the H&P, H&P addendum are all acceptable methods).

If, upon examination, the practitioner finds no change in the patient's condition since the H&P was completed, the practitioner 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.

Surgical/Procedure History and Physical – A history and physical shall be recorded before an operative or invasive procedure. If not present, the case will be delayed until the history and physical is present unless the physician states in writing that such delay would constitute a hazard to the patient (i.e. in a documented emergency). For such emergent surgical procedures, if time allows, a brief handwritten history and physical may substitute and a complete history and physical is required as soon as possible following the procedure.

For Obstetrics – The entire prenatal record may be used as the history and physical if it is updated to reflect the patient’s condition upon admission.

The History and Physical is good for the entire length of stay.

History and Physical Scope of Assessment - The history and physical must include the elements, based on service, indicated on the following table:
### MEDICAL HISTORIES AND PHYSICAL EXAMS

<table>
<thead>
<tr>
<th>Required Elements:</th>
<th>Outpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatients</td>
</tr>
<tr>
<td>Chief Complaint/Provisional/Pre-op Diagnosis</td>
<td>X</td>
</tr>
<tr>
<td>Details of Present Illness</td>
<td>X</td>
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<tr>
<td>Allergies</td>
<td>X</td>
</tr>
<tr>
<td>Current Medications</td>
<td>X</td>
</tr>
<tr>
<td>Medical and Surgical History</td>
<td>X</td>
</tr>
<tr>
<td>Social and Family History Appropriate to Patient’s Age</td>
<td>X</td>
</tr>
<tr>
<td>Inventory of Body Systems</td>
<td>X</td>
</tr>
<tr>
<td>Complete Physical Examination</td>
<td>X</td>
</tr>
<tr>
<td>Conclusions or Impressions</td>
<td>X</td>
</tr>
<tr>
<td>Plan of Care</td>
<td>X</td>
</tr>
</tbody>
</table>

### SECTION 2. CONFLICTS OF INTEREST

When any person, e.g., an officer, department chairman or committee member, has or reasonably could be perceived to have a conflict of interest or to be biased in any manner involving another Medical Staff appointee that comes before such person, or when any such person initiated the request for review involving that appointee, such person shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that person may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the chairman of any committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any person has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any person may be called to the attention of the chairman by any person with knowledge of the matter.
SECTION 3. EXCLUSIVE SERVICES

A. The Board may, from time to time, determine 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 Physicians selected by the Hospital and the Board. In those areas where services are exclusive, the physicians or group of physicians who are under contract to the Hospital shall assume exclusive responsibility for adequate medical staffing, continuous coverage, maintenance of standards, organization and operation of those areas. The Emergency Department, Pathology Department, Anesthesia Department and Radiology Department are currently subject to exclusive service contracts and treated as exclusive service areas by the Hospital and the Board.

B. Physicians practicing in those areas where services are exclusive will either be parties to the contract with the Hospital, 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.

C. Applications for appointment or reappointment to the Medical Staff in areas where services are exclusive will not be accepted for processing except for applications by Physicians who have been granted exclusive rights under a contract with the Hospital and Physicians employed or engaged by Physicians holding such exclusive rights to perform services under a contract with the Hospital.

D. The effect of expiration or termination of a contract between a Physician and the Hospital on a Physician's staff status and clinical privileges shall be governed solely by the terms of the exclusive service contract with the Hospital. No action, recommendation or decision by the Hospital or the Board concerning the expiration, termination or failure to renew any such contract shall be subject to or conditioned upon the exercise of rights under Articles VI or VII of these Bylaws. Physicians exercising privileges in areas where services are exclusive shall, upon termination of the contract or relationship described above, automatically relinquish those privileges notwithstanding any other provisions of these Bylaws, to the contrary.

SECTION 4. PEER TO PEER SUPPORT

Saint Alphonsus recognizes that peer to peer support for Medical Staff Members who have been involved in an unexpected adverse event or other significant patient care matter ("event") is an important and desirable element of an effective peer review process ("Peer to Peer Support"). Peer to Peer Support at Saint Alphonsus is confidential and protected under Idaho Code Section 39-1392 et seq. and Oregon Rev Statutes 41.675.7. Peer to peer support involved providing support to impacted Medical Staff Members in the form of listening, mentoring, informal, non-clinical counsel, and potential referral to other support services to help the Medical Staff Member on a personal level in follow up to an event. Medical Staff Members may be referred to the Medical Director of the Peer to Peer Support Program through the Case Identification Processes outlined in this policy. The Medical Director of the Peer to Peer Support Program will then triage and refer appropriate matters to a Peer to Peer Supporter, who may offer support to the identified Medical Staff Member. Peer to Peer Support is intended to provide personal support to Medical Staff
members as part of the peer review process, but is separate from, and not intended to supplant, the
evaluation of events and data by the Medical Staff and Saint Alphonsus to determine whether
opportunities for improvement exist or whether other follow up under the Medical Staff Bylaws is
necessary.
ARTICLE IV - PART A: APPLICATION PROCESS FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

SECTION 1. APPLICATION PROCESS

Requests for applications for appointment to the Medical Staff shall be made in writing to the Chief Executive Officer or his designee. Applications shall be submitted on forms prescribed by the Board after consultation with the Credentials Committee. Applications of individuals who fail to meet the threshold criteria for appointment and clinical privileges shall not be processed and the individual shall be so notified.

SECTION 2. INFORMATION

The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

A. Verification that applicant is authorized to work in the United States, including any necessary proof of United States citizenship or visa status of the applicant.
B. The names and complete addresses of at least three (3) physicians, dentists, podiatrists or other practitioners of the same professional discipline, as appropriate, who have observed and have knowledge of the applicant’s clinical and professional performance and can evaluate the applicant’s current medical or clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, ethical character, ability to work with others, and physical, mental and emotional ability to perform all requested privileges. These references may not be from individuals about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant.
C. The names and complete addresses of any and all hospitals or other institutions at which the applicant has worked or trained in the past ten (10) years.
D. Whether applicant's employment, medical staff membership, or clinical privileges have ever been reduced, suspended, diminished, revoked, refused, or limited at any health center or other health care facility, voluntarily or involuntarily, or whether the applicant has ever withdrawn their application for appointment, reappointment or clinical privileges or resigned before a health center’s or health facility’s Board made a decision;
E. Whether the applicant has ever been the subject of focused review at any health center or health care facility for reasons relating to professional competence or conduct, (i.e., other than routine review following the initial granting of privileges);
F. Whether the applicant has ever entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g. a corporate integrity agreement);
G. Whether the applicant has ever been disciplined or formally reprimanded because of
inappropriate conduct, disruptive behavior or unprofessional interactions (e.g. sexual harassment);

H. Whether the applicant has reduced their practice in the last twenty-four (24) months;

I. Whether applicant’s license to practice or federal or state narcotics registration(s) have ever been relinquished, denied, challenged, limited, suspended, or revoked, whether voluntarily (in lieu of disciplinary action or investigation) or involuntarily, in any state; whether any disciplinary actions have been initiated or are pending against the applicant by any licensure board; and whether the applicant has ever been asked to surrender their license. The submitted application shall include a copy of the applicant's current license to practice, as well as a copy of his federal and state narcotics certificate(s);

J. Whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage. The submitted application shall include a copy of the applicant's current malpractice insurance;

K. Whether the applicant has ever been refused or denied coverage or had coverage canceled, or had specific privileges excluded by a malpractice liability carrier;

L. Current professional liability insurance status and prior or pending professional liability claims or suits, including judgments or settlements;

M. Whether applicant is currently physically or mentally able to perform all of the clinical privileges requested, with or without a reasonable accommodation;

N. Whether the applicant is currently using illegal drugs or legal drugs in an illegal manner;

O. Whether the applicant is currently using any chemical substances(s) which in any way impair or limit his ability to practice medicine with reasonable skill and safety;

P. Whether applicant has ever been named as a defendant in any criminal proceedings or been arrested or charged with a crime, with details about any such instance(s);

Q. Whether applicant has been suspended, sanctioned, excluded or otherwise restricted from participating in any private, federal or state health insurance program (for example, Medicare, Medicaid, or Tricare), and whether the applicant is currently under investigation.

R. A complete chronological listing of the applicant's professional and educational appointments, employment, or positions.

S. Such other information as the Board may require.

SECTION 3. NATIONAL PRACTITIONER DATA BANK AND BACKGROUND CHECK

All applicants to the Medical Staff shall undergo querying of the National Practitioner Data Bank and undergo a criminal background check.

SECTION 4. UNDERTAKINGS

Every application for Staff appointment or reappointment shall be signed by the applicant and shall contain:

A. The applicant's specific acknowledgment that:

1. appointment/affiliation and clinical privileges is not a right;
2. the applicant’s request shall be evaluated in accordance with prescribed procedures defined in the Hospital and Medical Staff bylaws, policies and plans;
3. all recommendations relative to the application are subject to the ultimate action of the Hospital Board, whose decision shall be final;
4. the applicant has the responsibility to keep the application current by informing the Hospital, through the Chief Executive Officer, of any change in the areas of inquiry contained in the application;
5. appointment and continued clinical privileges remain contingent upon the applicant’s continued demonstration of professional competence and cooperation, the applicant’s general support of the Hospital, as evidenced by admission, treatment and continuous care and supervision of patients for whom the applicant has responsibility and acceptable performance of all responsibilities related thereto, as well as other factors deemed relevant by the Hospital; and
6. he has received and/or had an opportunity to read a copy of the bylaws/policies of the Hospital and such Hospital policies and directives as are applicable to his appointment/affiliation to the staff, including the bylaws and policy and plans presently in force.

B. A statement that the information submitted in the application, including all attachments, are true to the best of the applicant’s knowledge and belief, and that the applicant fully understands that any misleading statement or omission in the application discovered at any time may constitute grounds for denial of the application or cause immediate termination of hospital staff appointment and/or clinical privileges;

C. A statement that, if appointed/accepted or granted clinical privileges, the applicant agrees to:

1. refrain from fee splitting or other inducements relating to patient referral;
2. refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
3. refrain from deceiving patients as to the identity of any practitioner providing treatment or services;
4. seek consultation whenever necessary or required;
5. abide by generally recognized ethical principles applicable to his profession;
6. abide by all bylaws and policies of the Hospital, these Bylaws and policies and procedures and policy and plans of the Medical Staff, and the Catholic Health Care Directives as shall be in force during the time he is appointed to the Medical Staff or exercises clinical privileges in the Hospital;
7. provide continuous care and supervision as needed to all patients in the hospital for whom the applicant has responsibility;
8. accept committee assignments and such other duties and responsibilities, including teaching assignments, as shall be assigned by the Hospital Board and Medical Staff; and
9. participate in sufficient Continuing Education activities to meet the requirement for renewal of his practice license in the State of Idaho and that the majority of these hours will be in his specialty.
SECTION 5. BURDEN OF PROVIDING INFORMATION

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. He shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. Until the applicant has provided all information requested by the Hospital, the application will be deemed incomplete and will not be processed. Should information provided in the initial application for appointment change during the course of an appointment year, the appointee has the burden of providing information about such change to the Credentials Committee sufficient for the Credentials Committee’s review and assessment.

SECTION 6. PROFESSIONAL CONDUCT

Individuals appointed to the Medical Staff shall be expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical Staff leadership and Hospital Administration and personnel. Professional conduct shall also include, but not be limited to, each appointee's obligation to present himself or herself at the Hospital physically and mentally capable of providing safe and competent care to his or her patients.

SECTION 7. AUTHORIZATION TO OBTAIN INFORMATION

The following statements, which shall be included on the application form and which form a part of these Bylaws, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff and to all others having or seeking clinical privileges in the Hospital. By applying for appointment, reappointment or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his application, whether or not he is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment.

A. Immunity: To the fullest extent permitted by law, the applicant agrees to absolute and unconditional release of liability and waiver of any and all claims, lawsuits or challenges:

1. Against the Hospital and its representatives as defined in subsection C below, for acts performed in connection with evaluation of professional competence and qualifications; and
2. Against any third parties, as defined in subsection C below, who provide information to the Hospital and their representatives bearing on the applicant’s professional competence and qualifications, and consent to release of such information to the Hospital and their representatives and agree to execute general specific releases upon request of the Hospital in accordance with approved policies and these bylaws.

B. Authorization to Obtain Information: The applicant specifically authorizes the Hospital and its authorized representatives to consult with administrators and members of the medical staff of other hospitals and/or institutions and with others with whom the applicant has been
associated, including past and present malpractice carriers and attorneys who may have information as defined in subsection C below bearing on the applicant’s professional competence and qualifications. This authorization also covers the right to receive and inspect all information bearing on the applicant’s competence and qualifications in accordance with these bylaws.

The authorization acknowledges that credentialing information (including but not limited to all information on applications, references, data and reports which reasonably relate to qualifications, competency, ability to practice, professional ethics and/or conduct of an applicant or medical staff member) may be shared between Saint Alphonsus Health System and any hospitals and/or managed care organizations that have entered into a delegated credentialing agreement with Saint Alphonsus Health System in accordance with the approved policy.

C. Definitions

1. As used in this section, the term “Hospital and its authorized representatives” means the Hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the individual's application or conduct in the Hospital; the members of the Board and their appointed representatives; the Chief Executive Officer or his designee; other Hospital employees; consultants to the Hospital; the Hospital's attorney and his partners; associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon his application or conduct in the Hospital.

2. As used in this section, the term "third parties" means other hospitals, trustees, medical staffs and associations, licensing agencies, managed care plans, and other organizations and persons concerned with provider or physician performance and the quality of care.

3. As used in this section, the term "information" shall include but is not limited to both oral and written information, and shall include all records and documents, including medical records and otherwise privileged or confidential information; the phrase “bearing on professional competence and qualification” shall mean material which provides an evaluation of clinical ability, professional ethics, character, physical and mental health, emotional stability and other qualifications for appointment and/or clinical privileges.

SECTION 8. PROCESSING APPLICATIONS

The Medical Staff Office will collect and verify information contained in the application and supporting documentation, including primary source verification of current and past state licensure(s) as required by policy, specific relevant training, experience and current competence, as required and allowed by regulatory agencies. With the exception of the National Practitioner Data Bank query, all credentialing information that has been primary source verified by the Saint Alphonsus Health System Credentials Verification Organization may be accepted by Saint Alphonsus Medical Center - Nampa.
SECTION 9. DEFINITION OF COMPLETED APPLICATION

An application is considered complete after receipt of all information requested from the applicant, verification of its contents, and receipt of all references and other information or materials as delineated in these Bylaws or as may be required by local, state, and federal laws.

SECTION 10. TRAINING

Confirmation must be received by the Medical Staff Office that the applicant has successfully completed appropriate electronic health record training prior to admitting or managing patients.

ARTICLE VI - PART B: PROCEDURE FOR INITIAL APPOINTMENT

SECTION 1. EXPEDITED CREDENTIALING

See Expedited Credentialing Policy available in Policy and Plans Chapter IX, Section 6.

Any provisions in these Bylaws to the contrary notwithstanding, applications identified as having no apparent problems ("Expedited") may be transmitted to Executive Committee for evaluation following review by the department chairman and Credentials Committee chairman, or designees. With respect to such applications, any references throughout the Bylaws to the Credentials Committee shall be to the Executive Committee, as appropriate, it being the intention of the Medical Staff that an Expedited applicant may be evaluated by the Executive Committee only. Expedited applicants shall have no right to have an application transmitted directly to the Executive Committee, nor shall an applicant whose application was not transmitted directly to the Executive Committee be entitled, as a result, to any hearing and appeal rights under the Fair Hearing Process.

SECTION 2. SUBMISSION OF APPLICATION

The application for Medical Staff appointment shall be submitted by the applicant to the Chief Executive Officer or his designee. It must be accompanied by payment of such processing fees as may be established by the Board. After collecting references and other information or materials deemed pertinent, the Chief Executive Officer, or his designee, shall determine the application to be complete and transmit the application and all supporting materials to the department chair for evaluation, who shall transmit the application and all supporting materials to the Credentials Committee for evaluation. It is the responsibility of the applicant to see to it that the application is complete, including adequate responses from references. An incomplete application will not be processed.

SECTION 3. INITIAL PROCEDURE

Upon receipt of the completed application for appointment, the Medical Staff Office shall:

A. inform the chairman of each department in which the applicant seeks clinical privileges and
request recommendations; and
B. post the name of the applicant on the bulletin board so that each appointee to the Medical Staff may have an opportunity to submit to Credentials Committee, in writing, information bearing on the applicant's qualifications for Staff appointment. In addition, any person currently holding an appointment to the Medical Staff shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns about the applicant.

SECTION 4. DEPARTMENT CHAIRMAN PROCEDURE

The chairman of each department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for approving or disapproving the application and for delineating the applicant's clinical privileges. In cases where any applicant is requesting privileges outside his own department, such requests shall require a recommendation from the chairman of all departments involved, to the Credentials Committee. These recommendations shall be made a part of the Credentials Committee's report. As part of the process of making this recommendation, the department chairman has the right to meet with the applicant to discuss any aspect of his application, his qualifications and his requested clinical privileges.

SECTION 5. CREDENTIALS COMMITTEE PROCEDURE

A. The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the chairman of the clinical department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the Staff division and clinical privileges requested by him.
B. If, after considering the recommendations of the clinical departments concerned, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional clinical privileges.
C. As part of the process of making its recommendations, the Credentials Committee shall have the right to require the applicant to meet with the Committee to discuss any aspect of his application, his qualifications and his clinical privileges.

SECTION 6. CREDENTIALS COMMITTEE REPORT

A. Not later than ninety (90) days from its receipt of the completed application, the Credentials Committee shall make a written report and recommendation with respect to the applicant to the Executive Committee.
B. The Credentials Committee shall transmit to the Executive Committee the complete application and its recommendation that the applicant be appointed to the Medical Staff, that his application be deferred for further consideration, or that he be rejected for Medical Staff appointment. The chairman of the Credentials Committee, or his designee, shall be available to the Executive Committee to answer any questions that may be raised with
SECTION 7. SUBSEQUENT ACTION ON THE APPLICATION

A. When the recommendation of the Executive Committee is favorable to the applicant, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges. The applicant shall be notified in writing of the Board’s action within ninety (90) days.

B. When the recommendation of the Executive Committee is to defer the application for further consideration it must be followed within ninety (90) days by a subsequent recommendation to the Board through the Chief Executive Officer for appointment to the Medical Staff with specified clinical privileges, or for rejection of the application for Staff appointment. The applicant shall be notified in writing of the Executive Committee’s recommendation and the subsequent Board action within ninety (90) days.

C. When the recommendation of the Executive Committee would entitle the applicant to a hearing under the Fair Hearing Process, the Committee’s report and recommendation shall be forwarded to the Board through the Chief Executive Officer and the applicant shall be so notified in accordance with the Fair Hearing Process. The report shall not identify the applicant by name, and the reason for the recommendation shall be stated in general terms only, e.g., the application was denied for failure to meet the burden of proof about Qualifications. This report shall be transmitted to the Board for informational purposes, but the Board shall not act thereon until after the applicant has exercised or has been deemed to have waived his right to a hearing as provided in the Fair Hearing Process. The chairmen of the Credentials and Executive Committees, or their designees, shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation and that do not conflict with the Board’s role as an appellate body. A statement of the reasons for any recommendation of non-appointment, non-promotion or limitation in clinical privileges may be provided to the Chairman and/or Vice-Chairman of the Board. Neither the Chairman nor the Vice-Chairman of the Board shall participate on any Review Panel or Board deliberations pursuant to Article VI, Part C, Section 4 of these Bylaws, if such person has been advised of the reasons for therecommendation.

SECTION 8. TIME PERIODS FOR PROCESSING COMPLETED APPLICATIONS

Completed applications for Medical Staff appointment shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide guidelines for routine processing of applications:

A. Review and recommendation by department chairman within thirty (30) days after receipt of all necessary documentation;

B. Review and recommendation by Credentials Committee within sixty (60) days after receipt of all necessary documentation;

C. Review and recommendation by Executive Committee at its next regular meeting after
receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable; and

D. Final action by the Board within ninety (90) days of recommendation by the Executive Committee.

These time frames are not inclusive of time required for the hearing and appeals process as otherwise specified in the Fair Hearing Process.

ARTICLE VI- PART C: CLINICAL PRIVILEGES

SECTION 1. GENERAL

A. Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the Hospital. Each individual who has been given an appointment to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board, except as stated in policies adopted by the Board.

B. The clinical privileges recommended to the Board shall be based upon consideration of the following:

1. the applicant's education, training, experience, demonstrated current competence and judgment, references, relevant practitioner-specific data as compared to aggregate data (when available), morbidity and mortality data (when available), utilization patterns, and ability to perform the privileges requested competently and safely;
2. the applicant's ability to meet all current criteria for the requested clinical privileges;
3. availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;
4. adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;
5. evidence of an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant;
6. the Hospital's available resources and personnel;
7. any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntarily relinquishment of such licensure or registration;
8. any information concerning professional review actions, voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary relinquishment, limitation, reduction, or loss of clinical privileges at another hospital; and
9. other relevant information, including a written report and findings by the chairman of each of the clinical departments in which such privileges are sought.

SECTION 2. CLINICAL PRIVILEGES FOR DENTISTS

A. The scope and extent of the surgical procedures that a dentist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the
Chairman of the Department of Surgery. Prior to dental surgery, a medical history and physical examination of the patient shall be made and recorded by a Medical Staff Physician who is licensed to practice medicine pursuant to Chapter 18, Title 54, Idaho Code.

B. Oral and maxillofacial surgeons who admit patients without medical problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Board on recommendation of the Executive Committee.

C. The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff policy and plans and in compliance with the Hospital's bylaws and these Bylaws.

SECTION 3. CLINICAL PRIVILEGES FOR PODIATRISTS

A. A podiatrist must co-admit a patient with a Medical Staff Physician who is authorized to admit patients and who is licensed to practice medicine pursuant to Chapter 18, Title 54, Idaho Code, who shall assume responsibility for the non-podiatric medical care of the patient throughout his Hospital stay. Patients admitted to the Hospital for podiatric care must be given the same medical appraisal as patients admitted to other services. Privileges granted to podiatrists shall be limited to conditions of the human foot except as provided below:

B. Three classes of podiatric prerogatives shall be available:

1. Class I Privileges – Include non-invasive procedures only. This category allows consultations in the Hospital as well as non-surgical outpatient and inpatient care. The applicant must provide evidence of successful completion of one (1) year post-graduate residency training as approved by the Council on Podiatric Medical Education.

2. Class II Privileges - Include invasive procedures at or below the ankle joint (tibiotalar joint). Criteria for eligibility for Class II privileges will include all of the credentials as noted above for Class I privileges. The applicant must also provide evidence of successful completion of two (2) years of post-graduate residency training as approved by the Council on Podiatric Medical Education.

3. Class III Privileges – Include all the privileges of Class II with the additional privilege to perform a complete admission history and physical examination and to assess the medical risks of the procedure on the patient. Criteria for eligibility for Class III privileges will include all the credentials as noted above for Class II privileges. The applicant must also be deemed qualified to perform a complete admission history and physical examination and to assess the medical risks of the procedure on the patient by the Board on recommendation of the Medical Executive Committee.

C. Podiatrists holding Class I or Class II privileges, who co-admit patients may perform a podiatric history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Board on recommendation of the Executive Committee, provided, however, that a Medical Staff Physician who is authorized to admit patients and who is licensed to practice medicine pursuant to Chapter 18, Title 54, Idaho Code performs and signs a complete admitting history and physical examination.
SECTION 4. TELEMEDICINE PRIVILEGES

Physicians who have either total or shared responsibility for patient care, treatment and services through a telemedicine mechanism must be credentialed and privileged in accordance with the Medical Staff Telemedicine Policy found in the Policy and Plans, Chapter IX, Section 5.

ARTICLE VI – PART D: RESIDENTS

See Supervision of Residents Policy in Policy and Plans Chapter XII, Section 6.
SECTION 1. EXPEDITED CREDENTIALING

See Expedited Credentialing Policy in Policy and Plans Chapter IX, Section 6.

Any provisions in these Bylaws to the contrary notwithstanding, applications identified as having no apparent problems ("Expedited") may be transmitted to Executive Committee for evaluation following review by department chairman and Credentials Committee chairman, or designees. With respect to such applications, any references throughout the Bylaws to the Credentials Committee shall be to the Executive Committee, as appropriate, it being the intention of the Medical Staff that an Expedited applicant may be evaluated by the Executive Committee only. Expedited applicants shall have no right to have an application transmitted directly to the Executive Committee, nor shall an applicant whose application was not transmitted directly to the Executive Committee be entitled, as a result, to any hearing and appeal rights under the Fair Hearing Process.

SECTION 2. APPLICATION

Each current appointee who wishes to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form approved by the Board. The reappointment application shall be completed and returned within 30 days of receiving the application to the Medical Staff Office. Failure to submit an application by that time will result in automatic expiration of the appointee's appointment and clinical privileges at the end of their appointment.

SECTION 3. FACTORS TO BE CONSIDERED

Each current appointee who wishes to be reappointed to the Medical Staff shall meet the “Qualifications for Appointment and Continued Membership” set forth in Article I – Part A of these bylaws and the requirements set forth in Article VI – Part A Section 2B-Q and Sections 3-9 of these bylaws. In addition, recommendation for reappointment shall be based in part on the following:

A. Request for change in staff status or clinical privileges;
B. Reports of Quality Management, reflecting measurement, assessment and improvement of the following:
   1. medical assessment and treatment of patients;
   2. adverse privileging decisions;
   3. use of medications;
   4. use of blood and blood components
   5. use of operative and other procedure(s);
6. appropriateness of clinical practice patterns;
7. significant departures from established patterns of clinical practice; and

C. Sufficient evidence of the applicant’s professional practice performance in the previous appointment term to enable the department chairman to assess the applicant’s clinical competence. If such evidence is not available, applicant must provide references from two (2) appropriate peers of the same discipline sufficient for the department chairman to assess the applicant’s clinical competence;

SECTION 4. DEPARTMENT PROCEDURE

Prior to the end of the current appointment period, the department chairman shall review the applications of appointees desiring reappointment, together with the clinical privileges each appointee then holds. In addition, the chairman shall review any changes in appointment, Staff division, or clinical privileges.

The department chairman shall then submit to the Credentials Committee the list of individuals recommended for reappointment, any changes recommended in appointment, Staff division, or clinical privileges. The department chairman may make recommendation for non-reappointment as appropriate.

Recommendations for increase of clinical privileges by the department chairman shall be based upon relevant recent training and upon observation of patient care provided, review of the records of patients treated in this or other hospitals and review of all other records of the Medical Staff who participated in evaluating the appointee's delivery of medical care.

SECTION 5. CREDENTIALS COMMITTEE PROCEDURE

The Credentials Committee, after receiving recommendations from the chairman of each department, shall review all pertinent information available for the purpose of determining its recommendations for Staff reappointment, for change in Staff division, and for the granting of clinical privileges for the ensuing reappointment period.

The Credentials Committee shall prepare a list of persons currently holding appointment who are recommended for reappointment without change in Staff division and clinical privileges. Recommendations for non-reappointment and for changes in division or privileges, with supporting data and reasons attached, shall be handled individually.

The Credentials Committee shall transmit its report and recommendations to the Executive Committee which will then transmit its report and recommendations to the Board through the Chief Executive Officer in time for the Board to consider reappointments at its final scheduled meeting in each reappointment cycle. The applicant shall be notified in writing of the Board’s action within ninety (90) days.

When non-reappointment, non-promotion of an eligible current appointee, or a further limitation in clinical privileges is recommended, the Executive Committee report shall not identify the
individual by name, and the reason for such recommendation shall be stated in general terms only, e.g., the application was denied for failure to meet burden of proof about qualifications. This report shall be transmitted to the Board for informational purposes, but the Board shall not act thereon until the affected Staff appointee has exercised or has been deemed to have waived his right to a hearing as provided in the Fair Hearing Process. The chairmen of the Credentials and Executive Committees, or their designees, shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation and that do not conflict with the Board's role as an appellate body. Full disclosure of the reasons for any recommendation of non-appointment, non-promotion or limitation in clinical privileges by the Credentials Committee may be provided to the Chairman and/or Vice-Chairman of the Board. Neither the Chairman nor the Vice-Chairman of the Board shall participate on any Review Panel or Board deliberations pursuant to Article XI, Part D Section 4.

SECTION 6. MEETING WITH AFFECTED INDIVIDUAL

If, during the processing of a particular individual's reappointment, it becomes apparent to the Credentials or Executive Committees or their chairmen that the committee is considering a recommendation that would deny reappointment, deny a requested change in Staff division or clinical privileges, or restrict or reduce clinical privileges, the chairman of the Credentials or Executive Committee, as appropriate, shall notify the individual of the general tenor of the possible recommendation and ask him if he desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in the Fair Hearing Process with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the committee shall indicate, as part of its report to the Board, whether such a meeting occurred.

SECTION 7. PROCEDURE THEREAFTER

Any recommendation by the Executive Committee denying reappointment, a requested Change in Staff division or clinical privileges or recommending restriction or reduction of existing clinical privileges shall entitle the affected individual to the procedural rights provided in the Fair Hearing Process. The individual shall be notified of the recommendation in accordance with the Fair Hearing Process. The recommendation shall be forwarded to the Board for informational purposes, but the Board shall not act thereon until the individual has exercised or has been deemed to have waived his right to a hearing as provided in the Fair Hearing Process, after which the Board shall be given the committee's final recommendation and shall act on it. The chairman of the Credentials and Executive Committees, or their designees, shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation and that do not conflict with the Board’s role as an appellate body. A statement of the reasons for any recommendation of non-appointment, non-promotion or limitation in clinical privileges may be provided to the chairman and/or vice-chairman of the Board. Neither the chairman nor the vice-chairman of the Board shall participate on any review panel or board deliberations pursuant to Article XI, Part D, Section 4 of these Bylaws if such person has been advised of the reasons for the recommendation.
SECTION 8. TIME PERIODS FOR PROCESSING COMPLETED REAPPOINTMENT APPLICATIONS

Completed applications for reappointment to the Medical Staff shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide guidelines for routine processing of applications:

A. Review and recommendation by the department chairman within thirty (30) days after receipt of all necessary documentation;
B. Review and recommendation by the Credentials Committee within sixty (60) days after receipt of all necessary documentation;
C. Review and recommendation by the Executive Committee at its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable; and
D. Final action by the Board within ninety (90) days of recommendation by the Executive Committee.

These time frames are not inclusive of time required for the hearing and appeals process as otherwise specified in these Bylaws. A reappointment application is considered complete after receipt of all information requested from the applicant, verification of its contents, and receipt of any other information or materials as delineated in these Bylaws or as may be required by local, state, and federal laws.
ARTICLE VIII

TEMPORARY PRIVILEGES

ARTICLE VIII – PART A: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

SECTION 1. TEMPORARY CLINICAL PRIVILEGES FOR APPLICANTS

Temporary clinical privileges may be granted following receipt of a completed application for Medical Staff appointment, which has been processed and verified in accordance with Article I of these Bylaws. Temporary clinical privileges may be granted to fulfill an important patient care need or when an applicant with a complete, clean application is waiting review and approval of the appropriate medical staff committees and the Board.

These temporary clinical privileges may be granted for a time period not to exceed one hundred twenty (120) days. In exercising such temporary clinical privileges, the applicant shall act under the supervision of the chairman of the department in which the individual has requested primary privileges (or the chairman’s designee).

These temporary clinical privileges may be granted by the Chief Executive Officer (or designee) in consultation with the appropriate department chairman, the chairman of Credentials Committee, and the chairman of Executive Committee (or their designees).

SECTION 2. SPECIAL REQUIREMENTS

Special requirements of supervision and reporting may be imposed by the department chairman concerned on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer or his designee upon notice of any failure by the individual to comply with such special conditions.

SECTION 3. LOCUM TENENS

A. Admitting and Clinical Privileges

Locum tenens admitting and clinical privileges may be granted by the Chief Executive Officer (or designee) after consulting with the department chairman concerned, the chairman of the Credentials Committee, and the chairman of the Executive Committee (or designees), to a physician who is serving as a locum tenens for person(s) currently holding an appointment to the Medical Staff.

Locum tenens admitting and clinical privileges allow the physician to attend patients of that appointee for a period not to exceed ninety (90) continuous calendar days or more than one hundred and eighty (180) calendar days per year without applying for appointment to the Medical Staff. This shall be done in the same manner and upon the same conditions as set
forth in Article I of these bylaws.

Locum Tenens providers privileges will be approved for a maximum of one year. If the Locum Tenens provider will be returning after one year, he/she will need to reapply.

Exceptions to this requirement will be reviewed by the Medical Executive Committee on a case by case basis.

B. Application Process

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. Hospital affiliations for the past three (3) years or most recent five (5) hospitals in which the practitioner has practices for five (5) days or more, whichever is greater;
5. Two (2) peer references, preferably from the same specialty;
7. All other applicable basic requirements for membership, as outlines in the Medical Staff Bylaws, Article I, Part A;
8. Criminal Background check;
9. Idaho State Board of Pharmacy License.

SECTION 4. EXPIRATION AND RENEWAL OF TEMPORARY PRIVILEGES

Temporary privileges shall automatically expire at the end of any initially designated period or number of cases, unless earlier terminated or affirmatively renewed. Renewals shall be processed in a manner identical to the initial granting of temporary privileges. Expiration of temporary privileges shall not entitle the individual to a hearing under The Fair Hearing Process.

SECTION 5. TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

A. The Chief Executive Officer or, in his absence, his designee, may at any time, after asking for a recommendation of the President or the chairman of the department responsible for the individual's supervision, terminate an individual's temporary clinical privileges. Clinical privileges shall then be terminated when the physician's inpatients are discharged from the Hospital. In addition, when it is determined that the failure to immediately terminate temporary privileges may result in imminent danger to the health of any individual, the foregoing individuals may summarily terminate temporary clinical privileges and such termination shall be effective immediately.

B. The appropriate department chairman, or, in his absence, the President, shall assign to a Medical Staff appointee responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration whenever possible to the wishes of the patient in the selection of the substitute.
C. The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital. Neither the granting, denial or termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals, unless otherwise required by law.

D. Temporary privileges shall be automatically terminated at such time as the Credentials Committee recommends unfavorably with respect to the applicant's appointment to the Staff or at the Credentials Committee's discretion shall be modified to conform to the recommendations of the Credentials Committee that the applicant be granted different permanent privileges.

ARTICLE VIII – PART B– TEMPORARY CLINICAL PRIVILEGES FOR PRACTITIONERS NOT REQUESTING STAFF MEMBERSHIP

SECTION 1. TEMPORARY PRIVILEGE PROCESS

Temporary Clinical Privileges for Practitioners Not Requesting Staff Membership may be granted upon receipt of a completed application (provided by Saint Alphonsus Medical Center - Nampa, Inc.) which has been processed and verified.

These temporary privileges may be granted by the Chief Executive Officer (or designee) in consultation with the appropriate department chairman, the chairman of the Credentials Committee, and the chairman of Executive Committee (or their designees).

In exercising such temporary clinical privileges, the applicant shall act under the supervision of the chairman of the department in which the individual has requested privileges (or the chairman’s designee).

Temporary Clinical Privileges for Practitioners Not Requesting Staff Membership will be considered only if a completed application is received prior to the date of procedure.

SECTION 2. GRANTING TEMPORARY PRIVILEGES

These temporary privileges may be granted under the following circumstances:

A. Care of specific patient(s): To care for one or more specific patients for a specific period of time not to exceed thirty (30) days in any one (1) year.
   1. This circumstance is designed for the care of patient(s) who is not transportable and the expertise for such care is not available from current members of the Medical Staff.

B. Visiting surgeon assistant: To assist in surgery and/or learn a new procedure, limited to two (2) times per year.
   1. This circumstance is designed for a visiting surgeon assistant who is requesting clinical privileges to assist in surgery or as part of a teaching or learning program.

C. Proctoring physician: To assist the medical staff in completion of focused professional practice evaluation as needed;
SECTION 3. VERIFICATION

The following information must be obtained and verified before temporary clinical privileges are granted to a practitioner not requesting staff membership:

A. Current valid Idaho license to practice medicine or other evidence from the Idaho State Board of Medicine allowing the practice of medicine within the State of Idaho;
B. Current valid federal and state narcotics certificates, if applicable;
C. Current valid professional liability insurance coverage in amounts satisfactory to the Hospital;
D. One (1) or more positive references from medical peers regarding the applicant’s competence, training, and ability to perform the requested clinical privileges;
E. Positive letter(s) of reference from TJC and/or CMS accredited hospital(s) or medical facility(ies) where the applicant holds current clinical privileges (within past ninety (90) days). Practitioners not learning a new procedure must currently hold the requested clinical privileges at this facility(ies);
F. Report from National Practitioner Data Bank;
G. American Medical Association or American Osteopathic Association Profile; and
H. OIG Query to verify that the practitioner has not been excluded from participation in any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

SECTION 4. APPROVAL AND EXPIRATION OF TEMPORARY CLINICAL PRIVILEGES OF PRACTITIONER NOT REQUESTING STAFF MEMBERSHIP

A. Approval: Temporary clinical privileges do not become effective until a notice of temporary privileges has been approved and signed by the Chairman of the appropriate department, Chairman of Credentials Committee, Chief of Staff, and Chief Executive Officer (or their designees).
B. Expiration: Application for Temporary Clinical Privileges For Practitioners Not Requesting Staff Membership will expire automatically at the end of the designated period but in no case to exceed thirty (30) days.

SECTION 5. TERMINATION OF CLINICAL PRIVILEGES OF PRACTITIONER NOT REQUESTING STAFF MEMBERSHIP

A. The Chief Executive Officer (or designee), in consultation with the appropriate department chairman, the chairman of Credentials Committee, and the chairman of Executive Committee (or their designees) may suspend a practitioner granted these temporary clinical privileges whenever immediate action must be taken or where failure to take such action may result in an imminent danger to the health and safety of a patient, employee, or other person at Saint Alphonsus Medical Center - Nampa, Inc., or may result in disruption to the operations of Saint Alphonsus Medical Center - Nampa, Inc.
B. If a practitioner with these temporary clinical privileges is suspended or terminated, the appropriate department chairman shall have the authority to arrange for alternate medical coverage.
SECTION 6. RIGHTS OF A PRACTITIONER NOT REQUESTING STAFF MEMBERSHIP

A practitioner not requesting staff membership is not entitled to the procedural rights afforded by the hearing and appeal procedures outlined in Article X and XI of these Bylaws.

ARTICLE VIII - PART C: EMERGENCY CLINICAL PRIVILEGES

A. In an emergency involving a particular patient, a physician who is not currently appointed to the Medical Staff may be permitted by the Hospital to exercise clinical privileges to act in such emergency using all necessary facilities of the Hospital, including calling for any consultation necessary or desirable.

B. Similarly, in an emergency involving a particular patient, a physician currently appointed to the Medical Staff may be permitted by the Hospital to act in such emergency by exercising clinical privileges not specifically assigned to him.

C. When the emergency situation no longer exists, such physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or he does not request such privileges, the patient shall be assigned by the President, or his designee, to an appropriate person currently appointed to the Medical Staff. The wishes of the patient shall be considered in the selection of a substitute physician.

D. For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger. For the purpose of this section, "Hospital" means the Chief Executive Officer, or his/her designee, in consultation with the President.

ARTICLE VIII - PART D: GRANTING TEMPORARY PRIVILEGES IN THE EVENT OF A DISASTER

In the event of a disaster in which the emergency management plan has been activated, and the organization is unable to meet immediate patient needs, the Chief Executive Officer or the Medical Staff President (or their designees) are responsible for granting disaster privileges to volunteer licensed independent practitioners.

The process for granting disaster privileges is outlined in the Medical Staff Policy for Credentialing Practitioner(s) in the Event of Disaster found in Policy and Plans, Chapter IX, Section 4.
ARTICLE IX - PART A: PROCEDURES FOR REQUESTING ADDITIONAL OR INCREASED CLINICAL PRIVILEGES

SECTION 1. APPLICATION FOR ADDITIONAL OR INCREASED CLINICAL PRIVILEGES

Whenever, during the term of his appointment to the Medical Staff, an individual requests additional or increased clinical privileges for a procedure or service previously approved by the Medical Staff and the Board, he shall apply in writing to the Chief Executive Officer on a form approved by the Medical Staff, and shall include documentation of training and/or experience sufficient to justify such request, as appropriate.

The Medical Staff Office shall query the National Practitioner Data Bank (NPDB) and conduct primary source verification of current licensure, whenever feasible.

Individuals requesting an increase of clinical privileges to include a new procedure or new service must do so according to the Medical Staff New Privileges Policy and Procedure found in Policy and Plans Chapter IX, Section 3.

SECTION 2. TIME PERIODS FOR PROCESSING REQUESTS FOR ADDITIONAL OR INCREASED CLINICAL PRIVILEGES

Requests for additional or increased clinical privileges shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide guidelines for routine processing of applications:

A. Review and recommendation by the department chairman within thirty (30) days after receipt of request and all necessary documentation.
B. Review and recommendation by the Credentials Committee within sixty (60) days after receipt of request and all necessary documentation.
C. Review and recommendation by the Executive Committee at its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable.
D. Final action by the Board within ninety (90) days of recommendation by the Executive Committee.

These time frames are not inclusive of time required for the hearing and appeals process as otherwise specified in these Bylaws. A request for additional or increased privileges is considered complete after receipt of all information requested from the applicant, verification of its contents, and receipt of any other information or materials as delineated in these Bylaws or as may be
required by local, state, and federal laws.

The applicant shall be notified in writing of the Board’s action within ninety (90) days.

ARTICLE IX- PART B: PROCEDURES FOR REQUESTING DECREASE IN CLINICAL PRIVILEGES

Application for Decreased Clinical Privileges:

Whenever, during the term of his appointment to the Medical Staff, an individual desires to decrease his clinical privileges, he shall apply in writing to the Chief Executive Officer. All such applications will be processed in the same fashion and be subject to the same time periods as set forth in this Article IX, Part A, for requesting an increase in clinical privileges.

ARTICLE IX- PART C: PROCEDURES FOR CHANGE IN STAFF CATEGORY

Application for Change in Staff Category:

Whenever, during the term of his appointment to the Medical Staff, an individual desires to change Staff Category, he shall apply in writing to the Chief Executive Officer. All such applications will be processed in the same fashion and be subject to the same time periods as set forth in this Article IX, Part A for requesting an increase in clinical privileges.

ARTICLE IX– PART D: RESIGNATION FROM THE MEDICAL STAFF

Whenever, during the term of his appointment to the Medical Staff, an individual desires to resign, he shall submit a written resignation to the Chief Executive Officer. Unless the written resignation states a specific effective date, Medical Staff Membership and Clinical Privileges of such individual shall terminate fourteen (14) days from receipt of the written resignation.

ARTICLE IX- PART E: PROCEDURE FOR LEAVE OF ABSENCE

A. A Medical Staff member may, for good cause be granted a leave of absence by the Board for a definitely stated period of time not to exceed one (1) year. A leave of absence in excess of one (1) year may be granted on a case-by-case basis. A request for a leave of absence shall be made, in writing, to the chairman of the department in which the individual applying for the leave has his primary clinical privileges, and shall state the beginning and ending dates of the requested leave. The department chairman shall transmit the request, together with his recommendation, to the Executive Committee which shall make a report and a recommendation and transmit it to the Chief Executive Officer for action by the Board.

B. Where circumstances exist which would otherwise provide grounds for precautionary
suspension pursuant to the Corrective Action process, the President of the Medical Staff, the chairman of the department in which the individual applying for the leave has his primary clinical privileges, or the Chief Executive Officer may grant a temporary leave of absence, effective immediately, which shall remain effective for thirty (30) days or until action by the Board, whichever occurs sooner.

C. At the conclusion of the leave of absence, the individual who received the leave of absence shall submit a written request for reinstatement to the Chief Executive Officer. The request for reinstatement shall, at a minimum, summarize the professional activities undertaken during the leave of absence and shall provide evidence of his current ability to re-undertake the clinical privileges held before taking the leave of absence. The Chief Executive Officer shall forward the request for reinstatement to the Executive Committee for action. If requested, the individual shall also provide such other information as may be requested by the Executive Committee. After considering all relevant information, the Executive Committee shall then make a recommendation regarding reinstatement to the Board for final action.

D. In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different Staff division and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

E. The allowance of a Leave of Absence does not extend the appointment of any member of the Medical Staff. Members of the Medical Staff who request a Leave of Absence which will extend beyond the remaining period of their appointment may select one of the following two options:

1. Submit an application for reappointment prior to the start of the Leave of Absence with a request that it be processed without regard to the remaining period of reappointment; or
2. Submit and allow processing of his or her application for reappointment during the Leave of Absence. Applications for reappointment submitted during a Leave of Absence will be processed in the same manner as applications submitted by other members of the Medical Staff. Decisions concerning reappointment of a member of the Medical Staff on Leave of Absence will be based on information gathered to date and will be conditioned on the requirement that the member submit evidence of his or her ability to perform the privileges granted in support of their request for reinstatement under Subsection (c) above.

The failure of any member of the Medical Staff whose Leave of Absence extends beyond their period of appointment to submit an application for reappointment, as set forth in (1) and (2) above, will be treated as a voluntary resignation from the Medical Staff and relinquishment of all clinical privileges at the end of their period of appointment.
ARTICLE X– PART A: ROUTINE CORRECTIVE ACTION

SECTION 1. GROUNDS FOR ACTION

Whenever the President of the Medical Staff, the chairman of a clinical department, the chairman or a majority of any Medical Staff committee, the Chairman of the Board or the Chief Executive Officer has cause to question:

A. the clinical competence of any Medical Staff appointee;
B. the care or treatment of a patient or patients or the management of a case by any Medical Staff appointee;
C. the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies and procedures, policy and plans of the Hospital or its Board or Medical Staff; or
D. behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive of the orderly operations of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others so as to adversely affect patient care
E. a written request for an investigation of the matter shall be addressed to the Executive Committee, making specific reference to the activity or conduct which gave rise to the request.

SECTION 2. INITIATION OF INVESTIGATION

When a concern or question involving clinical competence or behavior/conduct has been referred to the Executive Committee, that committee shall determine either to discuss the matter with the appointee concerned or to begin an investigation. The Executive Committee may also, by formal resolution, initiate an investigation on its own motion. If the Board wishes to begin such an investigation, it shall also formally resolve to do so, but may delegate the actual investigation.

The chairman of the Executive Committee shall promptly notify the Executive Committee and the Chief Executive Officer in writing of all such requests and investigations, and shall keep them fully informed of all action taken in connection therewith.

SECTION 3. INVESTIGATIVE PROCEDURE

The Executive Committee shall meet as soon after receiving the request as practicable and if, in the opinion of the Executive Committee:

A. the request for investigation contains information sufficient to warrant a recommendation,
the Executive Committee, at its discretion, shall make such a recommendation, with or without a personal interview with the appointee; or

B. the request for investigation does not at that point contain information sufficient to warrant a recommendation, the Executive Committee shall immediately investigate the matter, appoint a subcommittee to do so, or, if it is deemed necessary, appoint an Investigating Committee. The Investigating Committee shall consist of three (3) Medical Staff members. This committee shall not include partners, associates or relatives of the affected individual. The Executive Committee, its subcommittee or the Investigating Committee, if any, shall have available to them 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 individual with respect to whom an investigation has been requested shall have an opportunity to meet with the Investigating Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in the Fair Hearing Process with respect to hearings shall apply. A summary of such interview shall be made by the Investigating Committee and included with its report to the Executive Committee. If a subcommittee or Investigating Committee was used, the Executive Committee may accept, modify or reject the recommendation it receives from that committee.

SECTION 4. PROCEDURE THEREAFTER

A. In acting after the investigation, the Executive Committee may:

1. take no action;
2. issue a written warning;
3. issue a letter of reprimand;
4. impose terms of probation;
5. impose a requirement for consultation;
6. recommend restriction or reduction of clinical privileges;
7. recommend suspension of clinical privileges; and/or
8. recommend revocation of Staff appointment.

B. Any recommendation by the Executive Committee for restriction or reduction of clinical privileges, for suspension of clinical privileges or for revocation of Staff appointment shall entitle the affected individual to the procedural rights provided in the Fair Hearing Process. Such a recommendation shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by Certified Mail, Return Receipt Requested. The Executive Committee shall also notify the Board of the recommendation, provided, however, that the notice shall not identify the individual by name, and the reason for such recommendation shall be stated in very general terms only, e.g., the restriction was imposed for patient care concerns. This notification shall be transmitted to the Board for information purposes, but the Board shall not act thereon until the affected staff member has exercised or has been deemed to have waived his right to a hearing as provided in the Fair Hearing Process. The chairman of the Executive Committee, or his designee, shall be available to the
Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation and that do not conflict with the Board's role as an appellate body. A statement of the reasons for any recommendation of non-appointment, non-promotion or limitation in clinical privileges by the Executive Committee may be provided to the Chairman and/or Vice-Chairman of the Board. Neither the Chairman nor the Vice-Chairman of the Board shall participate on any Review Panel or Board deliberations pursuant to Article XI, Part D, Section 4, if such person has been advised of the reasons for the recommendation.

C. If the action of the Executive Committee is less severe than restriction or reduction of clinical privileges, suspension of clinical privileges or revocation of Staff appointment, the action shall 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 shall be made to the Board through the Chief Executive Officer and the action shall stand unless modified by the Board. In the event the Board determines to consider modification of the action of the Executive Committee and such action would reduce clinical privileges, suspend clinical privileges or revoke Staff appointment, it shall so notify the individual, through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in the Fair Hearing Process.

**ARTICLE X- PART B: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES**

**SECTION 1. GROUNDS FOR PRECAUTIONARY SUSPENSION**

A. The President of the Medical Staff, the chairman of a clinical department, the Chief Executive Officer, or in his absence, his designee, or the Chairman of the Board shall each have the authority to suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual or may disrupt the orderly operations of the Hospital in a manner which imminently threatens individual or patient safety. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual, but is not a complete professional review action in and of itself. It shall not imply any finding of responsibility for the situation that caused the suspension.

B. Such precautionary suspension shall become effective immediately upon imposition and shall immediately be reported in writing to the Chief Executive Officer, or, in his absence, his designee or the President of the Medical Staff.

**SECTION 2. EXECUTIVE COMMITTEE PROCEDURES**

The individual who exercises his authority under Section 1 of this Part to suspend clinical privileges as a precaution shall immediately report this action to the chairman of the Executive Committee. At that point the Executive Committee shall take such further action as is required in the manner specified under Part A above. The precautionary suspension shall remain in force unless and until modified by the Executive Committee or the Chief Executive Officer, or until the
matter that required the suspension is finally resolved.

SECTION 3. CARE OF SUSPENDED INDIVIDUAL'S PATIENTS

Immediately upon the imposition of a precautionary suspension, the appropriate department chairman or, in his absence, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the Hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered by the department chairman in the selection of a substitute. It shall be the duty of the President of the Medical Staff and the department chairman to cooperate with the Chief Executive Officer in enforcing all suspensions.

SECTION 4. INITIATION BY GOVERNING BOARD

A. If no one authorized under Section 1 above to impose a precautionary suspension is available to do so, the Board, or its designee, may do so under the circumstances described in Section 1 above, provided the Board, or its designee, made reasonable attempts to contact the President of the Medical Staff, the Executive Committee and the chairman of the department to which the member is assigned before acting.

B. Such precautionary suspension is subject to ratification by the Executive Committee. If the Executive Committee does not ratify such suspension within two (2) working days, excluding weekends and holidays, it shall terminate automatically.

SECTION 5. REPORT TO IDAHO STATE BOARD OF MEDICINE AND NATIONAL PRACTITIONER DATA BANK

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

ARTICLE X - PART C: AUTOMATIC AND OTHER ACTIONS

SECTION 1. FAILURE TO COMPLETE MEDICAL RECORDS

A. The time limits, other requirements, and actions including voluntary suspension of certain privileges set forth in Chapter VI, Medical Records, of the Medical Staff Policy and Plans shall apply to completion of medical records by all individuals exercising clinical privileges in the Hospital, and shall be enforced in accordance with this Corrective Action Process.

B. It shall be the responsibility of the Director of Health Information Management, or his or her designee, to monitor the record completion patterns of the Medical Staff. The timely completion patterns of history and physical reports, operative reports, discharge summaries, and the delinquent records as set forth in Chapter VI, Medical Records, of the Medical Staff Policy and Plans and any delinquent record patterns shall be monitored as stated in these Bylaws and/or Medical Staff Policy and Plans. Findings shall be reported to the
SECTION 2. FAILURE TO SUBMIT DOCUMENTATION OF PROCTORING

It is the responsibility of every new member of the Medical Staff receiving proctoring and every member of the Medical Staff receiving proctoring for additional, new, or other privileges to ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of proctorship forms and the summary proctor report to the Medical Staff Office.

SECTION 3. LICENSURE AND FEDERAL AND/OR STATE NARCOTICS CERTIFICATE

A. Licensure

1. Revocation, Suspension, or Expiration: Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended, or expired, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
2. Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.
3. Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

B. Federal and/or State Narcotics License

1. Revocation, Suspension, or Expiration: Whenever the Federal and/or State narcotics license of a member required under the Medical Staff Bylaws to have one is revoked, suspended, or expired, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
2. Restriction: Whenever the Federal and/or State narcotics license of a member required under the Medical Staff Bylaws to have one is restricted, any clinical privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.
3. Probation: Whenever the Federal and/or State narcotics license of a member required under these Medical Staff Bylaws to have one becomes subject to probation, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

Individuals whose clinical privileges have been limited for these reasons must submit an application for reinstatement to the Hospital, which application must be approved by the Executive
Committee and Board prior to the reinstatement of the individual's clinical privileges; provided, however, if the underlying cause of the limitation on privileges is cured within 30 days (or such longer time as may be approved by the Executive Committee), then the individual will automatically be reinstated to the Medical Staff without the need to submit an application for reinstatement.

SECTION 4. FAILURE TO BE ADEQUATELY INSURED

If at any point the malpractice insurance coverage of a Medical Staff appointee or other individual exercising clinical privileges lapses, is terminated or otherwise ceases to be in effect, the individual's clinical privileges shall be voluntarily relinquished as of that date until the matter is resolved and adequate malpractice insurance coverage is restored. Individuals whose clinical privileges have been relinquished for this reason must submit an application for reinstatement to the Hospital, which application must be approved by the Executive Committee and Board prior to the reinstatement of the individual's clinical privileges, provided, however, if the underlying cause of the limitation on privileges is cured within 30 days (or such longer time as may be approved by the Executive Committee), then the individual will automatically be reinstated to the Medical Staff without the need to submit an application for reinstatement.

SECTION 5. FAILURE TO KEEP REQUIRED CERTIFICATIONS CURRENT

If at any point the required certifications of an individual with clinical privileges which requires current certification (such as ACLS, ATLS, PALS, NRP or ARLS) expires or otherwise ceases to be in effect, the individual’s clinical privilege(s) which require such certification shall be voluntarily relinquished as of the date of expiration until the individual becomes re-certified.

Reinstatement of appointment and/or clinical privileges that have been relinquished because of expired certification(s) shall be made following renewal of the certification providing such renewal occurs within six (6) months of expiration.

SECTION 6. DUES

All persons appointed to the Medical Staff shall pay annual Staff dues and assessments as may be required by the Medical Staff. Failure to pay the foregoing dues and assessments within sixty (60) days of the assessment date shall constitute voluntary relinquishment of Medical Staff appointment and/or clinical privileges. Reinstatement of appointment and/or clinical privileges that have been relinquished because of non-payment of dues and assessments shall be made following payment of the dues and assessments and any fines.

SECTION 7. PROCEDURE RELATED TO EXCLUSION FROM FEDERALLY-FUNDED HEALTH CARE PROGRAMS

A. Purpose:
The Medical Staff is aware that the hospital is prohibited by federal law from billing any federally-funded health care program for services which have been ordered by a practitioner who has been excluded from participation in federally-funded health care programs. The
Medical Staff is also aware that violation of this prohibition by the hospital can result in the imposition of sanctions against the hospital which can lead to the exclusion of the hospital from participation in federally-funded health care programs. Such exclusion of the hospital from participation in federally-funded health care programs would impair the delivery of quality health care to the community and would effectively eliminate the hospital as a viable place for the practice of medicine by the Medical Staff.

The following procedures have been established to reduce the possibility of sanctions being imposed against the hospital as a result of the exclusion of any applicant or member of the Medical Staff from participation in federally-funded health care programs.

B. Definition of "Excluded Practitioner" and identification of what is NOT an Excluded Practitioner:

1. "Excluded Practitioner" or “Exclusion (or “excluded”) from federally-funded health care programs” means that the Office of the Inspector General (OIG) has made a determination that the individual will not be reimbursed under Medicare, Medicaid, or any other federally-funded health care program for any item or service furnished, ordered or prescribed until the individual is reinstated by the OIG. Individuals or entities become "excluded practitioners" for violations such as program-related crimes, patient abuse, claims for excessive charges or unnecessary services, receiving or giving kickbacks, fraud, failing to repay the government for student loans, and/or failing to disclose required information to authorities.

2. The following are NOT "Excluded Practitioners":
   a. Practitioners who choose, on their own initiative, not to serve Medicare or Medicaid patients;
   b. Practitioners who are under audit or investigation;
   c. Practitioners who are disciplined for program violations by federal or state agencies (sanctioned practitioners). Sanctions can be in the form of a conviction or imposition of a civil monetary penalty by federal or state agencies.

C. Evidence of Exclusion by the OIG:
   Any of the following will constitute presumptive proof that an individual is an excluded practitioner and shall authorize action by the hospital hereunder:

1. Notification or admission to the hospital by the individual;
2. Receipt of Notice by the hospital from the OIG or HHS or similar governmental agency;
3. Identification of the individual as an excluded practitioner on the OIG excluded practitioner website;

D. Rejection of Applications from Applicants who are "Excluded Practitioners":
   New applicants to the Medical or Medical Associate Staffs who are currently excluded from any health care program funded, in whole or in part, by the federal government shall be notified that their applications will not be processed because they do not meet the basic qualifications for membership. They shall further be notified that they have no right to a hearing pursuant to the Fair Hearing Process.
E. Rights of Current Members of the Medical Staff who Become "Excluded Practitioners" During the Term of their Appointment:

1. The membership and clinical privileges of any member who becomes an Excluded Practitioner who has not received approval, after a Hearing regarding Effect of Exclusive from federal healthcare programs on a plan for continuance of membership and clinical privileges notwithstanding his or her status as Excluded Provider, shall be automatically suspended as of the date of the exclusion of the member from any federally-funded health care program. The member shall be given notice of the suspension in the most expeditious manner possible. Written notice of suspension shall also be given promptly.

2. Members who are excluded from any federally-funded health care program shall not have the right to a hearing under the Fair Hearing Process except as set forth below.

3. Notwithstanding section E2 above, any member who has been excluded from any federally-funded health care program who immediately notifies the Chief Executive Officer and submits a written request for a hearing to the President of the Medical Staff may receive a Hearing Regarding Effect of Exclusion from Federal Health Care Programs. A Request for a Hearing Regarding Effect of Exclusion from Federal Health Care Programs must be submitted to the President of the Medical Staff no later than thirty (30) days from the day the hospital receives Evidence of Exclusion as noted in Section 7C above.

4. The medical staff membership and clinical privileges of any member who is excluded from any federally-funded health care program who does not make a timely, written request for a Hearing Regarding Effect of Exclusion from Federal Health Care Programs as set forth in Section 7E3 above shall be automatically terminated. Written notice of termination shall be given promptly.

5. Any member who has reason to believe, after receiving notification from his or her Utilization and Quality Control Peer Review Organization (PRO), that he or she may become an Excluded Practitioner, may, in advance of his or her exclusion, request a Hearing Regarding Effect of Exclusion From Federal Health Care Programs. The hearing shall be conducted, and shall be limited as described in Section 7F below. Notwithstanding this Section 7E5, no member shall receive more than one (1) Hearing Regarding Effect of Exclusion From Federal Health Care Programs per exclusion. A member who requests a Hearing Regarding Effect of Exclusion From Federal Health Care Programs in advance of exclusion pursuant to this Section 7E5 shall not be entitled to a second Hearing Regarding Effect of Exclusion From Federal Health Care Programs after exclusion pursuant to Section 7F.

F. Hearing Regarding Effect of Exclusion from Federal Health Care Programs.

1. The Hearing Regarding Effect of Exclusion from Federal Health Care Programs shall be conducted in accordance with the Fair Hearing Process except as set forth in this Section 7F.

2. The sole issue to be addressed at the Hearing Regarding Effect of Exclusion from Federal Health Care Programs shall be whether the member may continue to hold medical staff membership and any clinical privileges without exposing the hospital, and/or other members of the medical staff, to liability for failing to comply with the regulations and/or laws regarding relationships with an individual or entity who is excluded from participation in federal health care programs.
G. Reinstatement:
If a member whose membership and privileges have been terminated pursuant to this Section is reinstated by the OIG during the balance of the term of his or her appointment, and less than one year after the date of termination, that individual may apply for reinstatement of his or her membership as if the termination were a leave of absence pursuant to Article IX, Part E of these Bylaws.

H. Provision for Continuity of Care:
Whenever a member's membership and privileges are terminated pursuant to this Section, the Chief of Staff and the member's department chairman shall take all necessary steps to ensure that any patients currently under the member's care in the Hospital shall immediately be brought under the care of another appropriate practitioner.

I. Termination Not A Reportable Event:
No report of any action taken based on a practitioner's exclusion from a health care program funded, in whole or in part, by the federal government shall be reported to the state medical board or to the National Practitioner Data Bank unless required by applicable law at the time the action is taken.
ARTICLE XI- PART A: INITIATION OF HEARING

An applicant or a person holding a Medical Staff appointment shall be entitled to a hearing whenever a recommendation unfavorable to him has been made by the Executive Committee regarding those matters enumerated in Part B, Section 2 below. The affected individual shall also be entitled to a hearing, before the Board enters a final decision, in the event the Board should determine to reject a favorable recommendation by the Executive Committee regarding any of these matters. The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital, whether Medical Staff or Board, and the duties of the Hearing Panel shall be so defined and so carried out.

ARTICLE XI - PART B: THE HEARING

SECTION 1. NOTICE OF RECOMMENDATION

A. When a recommendation is made which, according to these Medical Staff Bylaws, entitles an individual to a hearing prior to a final decision of the Board on that recommendation, the affected individual shall promptly be given notice by the Chief Executive Officer, in writing, return receipt requested. This notice shall contain a statement of the recommendation made.

B. Such individual shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing by the Hearing Panel hereinafter referred to. Said request shall be made by written notice to the President of the Medical Staff. In the event the affected individual does not request a hearing within the time and in the manner hereinabove set forth, he shall be deemed to have waived his right to such hearing and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

SECTION 2. GROUNDS FOR HEARING

No recommendation or action other than those hereinafter enumerated shall constitute grounds for a hearing:

A. denial of initial Medical Staff appointment;
B. denial of requested advancement in Medical Staff status;
C. revocation of Medical Staff appointment;
D. denial of Medical Staff reappointment;
E. revocation of Medical Staff reappointment;
F. denial of requested initial clinical privileges;
G. denial of requested increased clinical privileges;
H. involuntary restriction or reduction of clinical privileges;
I. suspension of clinical privileges, other than a precautionary suspension;
J. revocation of clinical privileges; or
K. imposition of a significant consultation requirement.

SECTION 3. UN-APPEALABLE ACTIONS

Neither voluntary nor automatic relinquishment of clinical privileges, as provided for in these Bylaws nor the imposition of an insignificant consultation requirement shall constitute grounds for a hearing but shall take effect without hearing or appeal.

SECTION 4. NOTICE OF HEARING AND STATEMENT OF REASONS

The President of the Medical Staff shall schedule the hearing and shall give notice, in writing, return receipt requested, to the person who requested the hearing. Notice shall include the place, time and date of the hearing. The hearing date shall not be less than thirty (30) days after the date of notice. Notice shall contain a statement that a professional review action has been proposed against the practitioner; a statement of the reasons for the proposed action; notice that the practitioner has a right to request a hearing and has thirty (30) days in which to do so; and a summary of the practitioner's rights in the hearing. This statement and information it contains may be amended or added to at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or clinical privileges of the person requesting the hearing, and that person and his counsel, if any, have sufficient time to study this additional information and to rebut it.

SECTION 5. DISCOVERY

A. Rights of Inspection and Copying:
   The affected practitioner may inspect and copy (at his expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the affected practitioner has in his possession or under his control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

B. Limits on Discovery
   The presiding officer shall rule on discovery disputes that the parties cannot resolve. Discovery may be denied, when justified to protect peer review involving other practitioners or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the practitioner under review, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

C. Ruling on Discovery Disputes
   In ruling on discovery disputes, the factors that may be considered include:
1. whether the information sought may be introduced to support or defend the charges;
2. whether the information is "exculpatory", in that it would dispute or cast doubt upon the charges of "inculpatory", in that it would prove or help support the charges and/or recommendations;
3. the burden on the party of producing the requested information; and
4. what other discovery requests the party has previously made.

D. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff
Evidence not provided by the affected practitioner, in response to a Medical Staff request for such information during an appointment, reappointment, or privilege application review or during corrective action, will be barred from the hearing by the presiding officer unless the practitioner can prove he previously acted diligently and could not have submitted the information.

E. Pre-Hearing Document Exchange
At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten (10) days prior to the hearing. A failure to comply with this rule is good cause for the presiding officer to grant a continuance. Repeated failures to comply shall be good cause for the presiding officer to limit the introduction of any documents not provided to the other side in a timely manner.

F. Witness Lists
Not less than ten (10) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

SECTION 6. HEARING PANEL

When a hearing is requested, the President of the Medical Staff, in consultation with members of the Executive Committee, shall appoint a Hearing Panel which shall be composed of not less than three (3) unbiased Medical Staff members not in direct economic competition with the affected practitioner. The Hearing Panel appointees shall not have actively participated in the consideration of this matter involved at any previous level. Such appointment shall include designation of the chairman. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. If necessary, members may be appointed from outside the Medical Staff.

SECTION 7. FAILURE TO APPEAR

Failure, without good cause, of the person requesting the hearing to appear and proceed at such a hearing shall be deemed a voluntary acceptance of the recommendations or actions pending, which
shall then become final and effective upon final Board action.

SECTION 8. POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond any time limit set forth in this Fair Hearing Process may be requested by anyone but shall be permitted only upon mutual agreement of the parties or by the presiding officer on a showing of good cause.

SECTION 9. DELIBERATIONS AND RECOMMENDATIONS OF THE HEARING PANEL

Within twenty (20) days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person except the presiding officer and shall render a written recommendation, accompanied by a report, which shall contain a statement of the basis for the recommendations made and shall deliver such report to the Chief Executive Officer.

SECTION 10. DISPOSITION OF HEARING PANEL REPORT

Upon its receipt, the Chief Executive Officer shall forward the Hearing Panel's report and recommendations, along with all supporting documentation, to the Board for further action. He shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the person who requested the hearing. If the hearing has been conducted by reason of an adverse recommendation by the Executive Committee, a copy of the report of the Hearing Panel shall be delivered by the Chief Executive Officer to the Executive Committee for informational purposes.

ARTICLE XI - PART C: HEARING PROCEDURE

SECTION 1. REPRESENTATION

The person requesting the hearing shall be entitled to be represented at the hearing by an attorney to examine witnesses and present his case. He shall inform the President of the Medical Staff in writing of the name of that person at least ten (10) days prior to the date of the hearing. The body whose decision prompted the hearing shall appoint a representative, who may be an attorney, to present its recommendations and reasons and to examine and cross-examine witnesses.

SECTION 2. PRESIDING OFFICER

A. The President of the Medical Staff, in consultation with the Chief Executive Officer, may appoint an attorney at law as presiding officer. Such presiding officer may not be legal counsel to either party. He must not act as a prosecuting officer, or as an advocate for the Board, the Executive Committee or the individual. He may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but he shall not be entitled to vote on its recommendations.

B. If no presiding officer has been appointed, the chairman of the Hearing Panel shall be the presiding officer and shall be entitled to vote.

C. The presiding officer shall act to insure that all participants in the hearing have a reasonable
opportunity to be heard and to present all oral and documentary evidence, subject to reasonable limits on the number of witnesses and duration of directing cross-examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or prevent abuse of the hearing process, that decorum is maintained throughout the hearing and that no intimidation is permitted. He shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with this Fair Hearing Process, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence. In all instances, he shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the presiding officer is acting at all times to see that all relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Board. The presiding officer may also conduct argument by counsel on procedural points outside the presence of the hearing panel unless the panel wishes to be present.

SECTION 3. RECORD OF HEARING

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital. Each party may have a copy of the transcript upon payment of the costs for preparing the same. The Hearing Panel shall order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this state.

SECTION 4. RIGHTS OF BOTH SIDES

At a hearing, both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues and to rebut any evidence. If the person requesting the hearing does not testify in his own behalf, he may be called and examined as if under cross-examination.

SECTION 5. ADMISSIBILITY OF EVIDENCE

The hearing shall not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall 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. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

SECTION 6. OFFICIAL NOTICE

The presiding officer shall 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 this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall 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. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

SECTION 7. BASIS OF DECISION

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

A. oral testimony of witnesses;
B. memorandum of points and authorities presented in connection with the hearing;
C. any material contained in the Hospital's files regarding the person who requested the hearing, so long as this material has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;
D. any and all applications, references, and accompanying documents;
E. all officially noticed matters; or
F. any other evidence that has been admitted.

SECTION 8. BURDEN OF PROOF

A. At any hearing involving any of the following grounds for hearing: denial of initial Medical Staff appointment, denial of requested change in Medical Staff division, denial of Medical Staff reappointment, revocation of Medical Staff appointment, or denial of a request for initial or additional clinical privileges, it shall be incumbent on the person who requested the hearing initially to come forward with evidence in support of his position.

B. in cases involving an involuntary restriction or reduction of clinical privileges or a suspension of total privileges for a term, it shall be incumbent on the body whose recommendation prompted the hearing initially to come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in such person’s support.

C. In all cases in which a hearing is conducted under this Fair Hearing Process, after all the evidence has been submitted by both sides, the Hearing Panel shall recommend against the person who requested the hearing unless it finds that said person has proved, by a preponderance of the evidence, that the recommendation which prompted the hearing is unreasonable, not sustained by the evidence or otherwise unfounded.

SECTION 9. ADJOURNMENT AND CONCLUSIONS

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.
ARTICLE XI - PART D: APPEAL

SECTION 1. TIME FOR APPEAL

Within ten (10) days after the parties have received the Hearing Panel's decision, either party may request an appellate review. The request shall be in writing, and shall be delivered to the Chief Executive Officer either in person or by certified mail, and shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within ten (10) days as provided herein, the parties shall be deemed to have accepted the recommendation involved and it shall be forwarded to the Board for final action.

SECTION 2. GROUNDS FOR APPEAL

The grounds for appeal from an adverse recommendation shall be that:

A. there was substantial failure on the part of the Executive Committee or Hearing Panel to comply with the Hospital or Medical Staff Bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing;
B. the recommendations were made arbitrarily, capriciously or with prejudice; or
C. the recommendations were not supported by the evidence.

SECTION 3. TIME, PLACE AND NOTICE

Whenever an appeal is requested as set forth in the preceding sections, the Chairman of the Board shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The Board shall cause both parties to be given notice of the time, place and date of the appellate review. The date of appellate review shall 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 an appointee who is under a suspension then in effect the appellate review shall be held as soon as the arrangements may reasonably be made. The date of the appellate review may be extended by the Chairman of the Board for good cause.

SECTION 4. NATURE OF APPELLATE REVIEW

The Chairman of the Board shall appoint a Review Panel composed of not less than three (3) of its own members (other than the Chairman or Vice-Chairman, who shall not participate on the Review panel or any deliberations of the Board) to consider the record upon which the recommendation before it was made. The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it was deprived of the opportunity to admit it at the hearing and then only at the discretion of the Review Panel. Each party shall have the right to present a written statement in support of its 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 shall recommend final action to the Board. After determining whether any of the grounds for appeal, set
forth in Part D, Section 2 above, exists, 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, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. The Chairman shall appoint an Acting Chairman who shall preside over the Board’s review of the recommendation of the Review Panel.

SECTION 5. FINAL DECISION OF THE BOARD

Within thirty (30) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the Executive Committee in person or by certified mail.

SECTION 6. FURTHER REVIEW

Except when the matter is referred for further action and recommendation in accordance with Section 4 of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendations shall 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 shall, in no event, exceed thirty (30) days in duration, except as the parties may otherwise stipulate.

SECTION 7. RIGHT TO ONE APPEAL ONLY

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one evidentiary hearing and appellate review on any single matter which may be the subject of an appeal. Further, an applicant may not reapply for appointment to the Medical Staff and the appointee may not apply for reappointment or an increase in clinical privileges for a period of two (2) years from the date of a final Board decision, following a hearing, unless the Board provides otherwise in its written decision.

SECTION 8. REPORT TO IDAHO STATE BOARD OF MEDICINE AND NATIONAL PRACTITIONER DATA BANK

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

SECTION 9. CONSTRUCTION WITH HEALTH CARE QUALITY IMPROVEMENT ACT

This Fair Hearing Process shall be construed, wherever reasonable, to be consistent with the Health Care Quality Improvement Act. In the event of any conflict, the provisions of this Fair Hearing Process shall control.
The Executive Committee, with the approval of the Board, shall adopt such policy and plans, and procedures and guidelines as may be necessary to implement more specifically the general principles of conduct found in these Bylaws. Such policy and plans shall have the same force and effect as these Bylaws. They shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards.

The policy and plans, and procedures and guidelines may be amended, repealed or added by the Executive Committee provided that there is communication of the proposed amendments, additions or repeals between the Medical Staff and Executive Committee. Copies of the proposed amendments, additions or repeals are posted in the Doctor’s Lounge and made available to all members of the Executive Committee fourteen (14) days before being voted on and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff be brought to the attention of the Executive Committee before the change is voted upon. The Executive Committee will communicate to the medical staff at the time it adopts a policy and procedure, a rule or regulation, or amendment thereto. Amendments, repeals or additions shall become effective only when approved by the Board.

In the event of a documented need for an urgent amendment to policy and plans necessary to comply with law or regulation, the Executive Committee may provisionally approve an urgent amendment without prior notification of the medical staff. In such an event the Medical Staff will be immediately notified by the Executive Committee so there is opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the Executive Committee is implemented. If necessary (in the event of conflict) a revised amendment is then submitted to the Board for action.
ARTICLE XIII

AMENDMENTS

These Bylaws shall be reviewed as necessary for amendment to reflect the Hospital's current practices with respect to Medical Staff organization and functions.

All proposed amendments of these Bylaws, whether initiated by the Medical Staff or the Board, shall be referred to the Executive Committee and shall be submitted for vote to the Medical Staff upon request of the Executive Committee or a petition signed by at least ten percent (10%) of Medical Staff members eligible to vote, provided that they shall have been posted in the Doctor’s Lounge for at least fourteen (14) days.

Amendments shall be effective upon the affirmative vote of a majority of the eligible Medical Staff members voting on the matter by mailed secret ballot and approval of the Board, which shall not be unreasonably withheld.

Neither the Medical Staff nor the Board shall unilaterally amend these Bylaws, with the exception of such amendments to the Bylaws as are technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. The Executive Committee shall have the power to adopt such amendments and they shall be effective immediately and shall be permanent if not disapproved by the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. The Executive Committee will communicate to the medical staff at the time it adopts a bylaws revision or amendment thereto. Amendments, repeals or additions shall become effective only when approved by the Board.

Copies of bylaws and policy and plans will, at all times, be available for review by members of the Medical Staff in the Doctor's Lounge.
These Bylaws are adopted and made effective February 17, 2022 superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges in the Hospital shall be taken under and pursuant to the requirements of these Bylaws.

APPROVED by the Medical Staff on December 13, 2021.

Steven Von Flue, MD
President of the Medical Staff

ADOPTED by the Saint Alphonsus System Quality Board on February 17, 2022.

Travis Leach, MBA
President, Saint Alphonsus Medical Center-Nampa
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SECTION 1. WHO MAY ADMIT PATIENTS

A patient may be admitted to the Hospital only by physicians who have been appointed to the Staff who have privileges to do so or by authorized Advanced Practice Professionals (APPs) who have privileges to do so. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Hospital has facilities and personnel. When the Hospital does not provide the services required by a patient or a person seeking necessary medical care, or for any reason cannot be admitted to the Hospital, the Hospital or attending physician, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient and in accordance with applicable law. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

SECTION 2. ADMITTING PHYSICIAN'S RESPONSIBILITIES

Each patient admitted to the hospital shall be the responsibility of the designated appointee to the Medical Staff who admits the patient. Such appointee shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, and for necessary special instructions, and to round on the patient at least daily, except for on the days of admission and discharge. Whenever these responsibilities are transferred to another Staff appointee, a note documenting transfer of responsibility for the patient to another Staff appointee shall be entered in the progress notes of the patient’s medical record at or before the time of the transfer of responsibility. Prior to transferring responsibility for an admitted patient, the admitting appointee shall be responsible for providing the Hospital with such information concerning the patient as may be necessary to protect the patient or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

SECTION 3. ADMITTING CERTIFIED NURSE MIDWIFE RESPONSIBILITIES

Each low-risk obstetrical patient admitted to the Hospital by a certified nurse midwife shall be the responsibility of the certified nurse midwife who admits them, unless care has been transferred to the sponsoring physician or group or the on-call physician or their designee. The certified nurse midwife must document the name of the collaborating/sponsoring physician in the admitting orders at the time of admission. The certified nurse midwife shall be responsible for the obstetrical care and treatment of the patient within the scope of their privileges in collaboration with a sponsoring physician, for the prompt completeness and accuracy of the medical record, and to round on the patient at least daily during their obstetrical stay. Whenever these responsibilities are transferred to the sponsoring physician or group or on-call physician or their designee, a note documenting transfer of responsibility shall be entered in the progress notes of the patient’s medical record at or before the time of the transfer of responsibility. Prior to transferring responsibility, the admitting certified nurse midwife shall be responsible for providing the Hospital with such
information concerning the patient as may be necessary to protect the patient or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

SECTION 4. AD-HOC SPONSORING PHYSICIANS FOR CERTIFIED NURSE MIDWIVES

A certified nurse midwife may collaborate, on a patient-by-patient basis, with any qualified member of the medical staff with full obstetric privileges who agrees to act as an Ad-Hoc Sponsoring Physician. A member of the medical staff who agrees to act as an Ad-Hoc Sponsoring Physician must document that agreement in the progress notes of the patient’s medical record at or before the time collaboration begins. A member of the medical staff who acts as an Ad-Hoc Sponsoring Physician shall be responsible and available to contribute his or her respective expertise in the provision of patient care to the patient, to discuss treatment of the patient with the certified nurse midwife, to cooperate in the management and delivery of health care to the patient, to consult to the midwife concerning the patient and to accept referral of the patient if necessary.”

SECTION 5. ALTERNATE COVERAGE

Each Medical Staff appointee, or authorized APP, shall provide assurance of availability of adequate professional care for his or her patients in the Hospital by being available or having available an alternate Medical Staff appointee with whom prior arrangements have been made by such Staff appointee and who has clinical privileges at the Hospital sufficient to care for the patient. In the event arrangements have been made for such alternate coverage which are not documented on the then current call schedule for the appointee a note documenting the temporary transfer of responsibility for the patient to another Staff appointee shall be entered in the progress notes of the patient’s medical record at or before the time of the transfer of responsibility. Failure to meet the above requirements may result in loss of clinical privileges.

SECTION 6. EMERGENCY RESPONSIBILITIES

See Emergency Department Policy and Procedure Manual.

A. Medical Screening Examinations – All persons who present themselves to the hospital with a request for examination or treatment of a medical condition will receive an appropriate medical screening examination and treatment as required by the federal antidumping laws and regulations and by the Hospital’s Policy for Treatment and Transfer of Individuals Who Request Emergency Medical Services (EMTALA). The results of this medical screening examination, and a determination of whether the patient has an emergency medical condition, will be documented in the medical record.

B. Emergency Admissions - In the case of emergency admissions, patients who do not already have a personal admitting physician will be assigned to a Medical Staff appointee with privileges in the clinical department to which the diagnosis indicates an assignment. Where departmental responsibility is not clear, the ranking available officer of the Medical Staff shall have the ultimate responsibility to determine the appropriate clinical department. The chairman of each clinical department shall provide an assignment schedule for attendance to such patients. Appointees who receive an emergency admission shall, at a minimum, and without regard to
ability to pay, provide all treatment required to stabilize the Emergency Admission patient and shall otherwise comply with the requirements of the federal antidumping laws and regulations.

C. Call Requirements – The on-call requirements for each physician shall be established for its members by each department and submitted to the Executive Committee for approval. The on-call requirements shall take into consideration the number of specialists and subspecialists in the department and the likelihood of receiving on-call assignments. If there are not a sufficient number of specialists in a particular field to reasonably provide on-call coverage for the emergency room on a full time basis, then the Executive Committee, working with the department and Hospital Administration shall develop alternative methods of providing coverage for the particular specialty.

D. Emergency Call – Any Medical Staff member who has been scheduled to serve on the Hospital’s Emergency Call Panel (“Panelist”) shall provide “timely consultation” when requested to do so by or at the direction of another Medical Staff member in accordance with the federal antidumping laws and regulations. Courtesy Staff appointees who have agreed to serve on the Hospital’s Emergency Call Panel may not limit their availability while “on call” but must provide “timely consultation” without regard to patient identity, in accordance with the federal antidumping laws and regulations.

Each Panelist must inform the Emergency Room how to reach him immediately while on call, and must remain in a location from which he can reach the Hospital within fifty (50) minutes of a call. For purposes of this subsection, “timely consultation” means not more than ten (10) minutes telephone response time and within a reasonable period of time as dictated by the patient’s clinical circumstances, but not more than fifty (50) minutes before arriving. A Panelist who is unable to provide coverage during his scheduled time is responsible for arranging, in advance, for coverage by another equally qualified Medical Staff member with appropriate clinical privileges. If a Medical Staff member who is on call does not provide timely consultation when requested or cannot be reached, the Hospital Chain of Command Policy shall be followed and the matter will be referred to the Executive Committee for appropriate corrective action.

E. Mass casualty assignments – All physicians will be called to the Hospital by assigned personnel. Physicians report to the Control Center for assignment to the areas where assistance is needed. The signing-in process establishes the priority for staffing by physicians. The Chairman of the Emergency Department or the Emergency Physician on duty at the time of the disaster is in charge of the triage. In the event evacuation of patients is required from the Hospital premises, dismissal will be authorized by the physician assigned to the department. All physicians on the Staff specifically agree to relinquish direction of the professional care of their patients to the physician assigned to each area during a disaster.

F. Use of Registered Nurses to Perform Medical Screening Examinations Under the Federal Anti-Dumping Laws and Regulations for Conditions Related to Pregnancy and Labor - Registered Nurses of the Obstetrics Department are determined, pursuant to federal law, to be qualified to provide Medical Screening Examinations to pregnant women having contractions to determine whether they are in active labor or whether they have a urinary tract infection, and to assess fetal
well-being. The Registered Nurses are determined to be qualified with proof of current competency.

G. Use of Mid-Level Practitioners to perform Medical Screening Examinations Under the Federal Anti-Dumping Laws and Regulations – Nurse Practitioners and Physicians Assistants are determined, pursuant to federal law, to provide Medical Screening Examinations to persons who present themselves to the hospital with a request for examination or treatment. Nurse Practitioners, and/or Physicians Assistants are determined to be qualified in accordance with their applicable approved privileges.

H. Use of Registered Nurses, Nurse Practitioners, and Physicians Assistants to Certify Transfers under the Federal Anti-Dumping Laws and Regulations - Registered Nurses, Nurse Practitioners, and Physicians Assistants are authorized, pursuant to federal law, to sign a certification for transfer to another facility in consultation with the physician.

I. Treatment of Patients in the Emergency Department by Non-Emergency Department Physicians - Members of the Medical Staff who are not under contract to provide emergency medicine services in the Emergency Department may meet their patients, for the purpose of providing medical treatment, in the Emergency Department, subject to the following conditions and requirements:

1. Subject to subsection (e) above, all patients who present to the Emergency Department will be triaged and will receive a Medical Screening Examination by an Emergency Department Physician, Nurse Practitioner, or Physicians Assistants unless their personal physician is physically present in the Emergency Department. In that case, the personal physician may conduct the Medical Screening Examination provided he/she has privileges at the Hospital to do so. All such examinations shall be conducted in accordance with the Hospital and Emergency Department policies, protocols and procedures and the federal anti-dumping laws and regulations. The results of the Medical Screening Examination and a determination whether the patient has an emergency medical condition, will be documented in the medical record by the examiner.

2. Any member of the Medical Staff who is not under contract to provide emergency medicine services in the Emergency Department who provides a Medical Screening Examination as set forth in (1) above shall provide such examination, and any subsequent stabilization and/or treatment in accordance with the Hospital’s Policy for Treatment and Transfer of Individuals Who Request Emergency Medical Services (EMTALA).

SECTION 7. PRE-ADMISSION LABORATORY TESTS

Pre-admission testing for elective surgical patients shall be authorized by the attending physician in accordance with minimum requirements as set forth in the Anesthesia Preoperative Lab/Diagnostic Testing Protocol.

SECTION 8. CONTINUED HOSPITALIZATION

The attending physician is required to routinely document the need for continued hospitalization
after specific periods of stay. This statement must contain:

A. An adequate written record of the reason for continued hospitalization and professional services furnished. A simple reconfirmation of the patient's diagnosis is not sufficient.
B. The estimated period of time the patient will need to remain in the Hospital.
C. Plans for post-hospital care. Upon request of the Utilization Review Committee, the attending physician must provide written justification of the necessity for continued hospitalization of any patient, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Executive Committee for appropriate action.
CHAPTER II

MEDICAL ORDERS

SECTION 1. POLICY ON ORDERS

A. Orders must be clear, legible and complete. Orders that are illegible or incomplete will not be carried out until rewritten or clarified.

B. A patient care order directs the performance or administration of a diagnostic test, treatment, procedure, prescribed medication, intervention or therapy. Providers within the scope of their practice and license may create such orders.

C. Orders should be processed in the Electronic Health Record (EHR)

D. Procedure:
   1. All orders will be dated, timed, and authenticated by written or electronic signature.
   2. Illegible handwritten signatures must be accompanied by a legible printed name.
   3. Orders must be adequately clear, specific and complete to direct patient care. For example, orders such as "continue previous meds," "resume preoperative meds," or "discharge on current meds" are not authorized.
   4. Order sets (e.g. paper sets, EHR Favorites or Power Plans) are authorized when dated, timed, and authenticated by written or electronic signature.
   5. Unapproved abbreviations and symbols, as defined by medical center policy, may not be used in orders, dictations, or other medical record entries.
   6. Orders may not be sent via text, EHR tasking/instant messages, in progress notes or via Halo Spectrum.
      a. The use of verbal orders is limited to clinical situations where it is impractical for orders to be entered into the medical record (e.g. while performing a procedure, emergent situations, or situations when physicians do not have access to remote computer devices or the patient chart).
      b. The following Saint Alphonsus colleagues are authorized to receive and input the verbal order into the medical record:
         • Registered Nurse (RN)
         • Licensed Practical Nurse (LPN)
         • Registered Therapist
         • Respiratory Care Practitioner
         • Pharmacist
         • Dietitian
         • Physician's Assistant (PA)
         • Nurse Practitioner (NP)
         • Medical Assistant (MA) in outpatient clinics
         • Specialized Procedure Technologists
         • Registered Radiology Technologist
         • Radiation Therapist
         • Radiation Dosimetrist
• Radiation Physicist

c. When a verbal/telephone order is taken, it must be documented and read back to the authorized person giving the order to confirm. The order should contain a statement that the order was confirmed after being read back. For Example:

- For paper based medical records:
  o VORB (Verbal Order Read Back), followed by the signature of the person taking the order.

- For electronic medical records:
  o Select appropriate communication order type (e.g. 'verbal order' or 'phone order')
  o These orders are routed to the provider for electronic signature

SECTION 2. MEDICATION ORDERS

A. If patients bring their own medications to the Hospital, these medications shall not be administered unless the attending physician or authorized APP has written an order for their administration. The attending physician or authorized APP shall order all medications specifically by name, dose, route and frequency. All medications must be positively identified by the Pharmacy prior to administration and shall bear a label from the pharmacy indicating that the medications belong to an individual patient and have been verified to be the medication ordered and labeled as such. Positive identification of patient’s own medications shall be performed using a validated computerized database listing FDA registered imprints and designated drug codes. Only medications bearing FDA imprints and drug codes can be positively identified. Any medications presented for use in the form of an oral liquid, injectable solution or herbal preparation cannot be positively identified and, therefore, cannot be administered within the Hospital. If any medications are brought into the Hospital and are not ordered by the attending physician or authorized MLP, they shall be sent home with a family member. If a family member is not available, they shall be packaged, sealed and returned to the patient at the time of discharge from the Hospital. Any medications not claimed by the patient or a family member within 30 days of discharge will no longer be the responsibility of the Hospital and will be destroyed.

B. Stop Orders: See Automatic Stop Orders Multidisciplinary Protocol:
CHAPTER III

CONSULTATIONS

SECTION 1. WHO MAY GIVE CONSULTATIONS

Any qualified physician with clinical privileges in this Hospital can be asked for consultation within his area of expertise. In circumstances of grave urgency, or where consultation is required by the rules of the Hospital, the Chief Executive Officer, the President or the appropriate department chairman shall at all times have the right to call in a consultant or consultants.

SECTION 2. REQUIRED CONSULTATIONS

A. Consultations are required in all cases in which, in the judgment of the attending physician:
   1. the diagnosis is obscure after ordinary diagnostic procedures have been completed;
   2. there is doubt as to the best therapeutic measures to be used; or
   3. unusually complicated situations are present that may require specific skills of other physicians.

B. Authorized APPs must obtain consultations as prescribed in their privilege form

C. It shall be the responsibility of all individuals exercising clinical privileges to obtain any required consultations. Requests for urgent consultations shall be verbally communicated by the requesting practitioner to the consulting practitioner. All other requests for consultations may be made by written order. All requests for a consultation shall be entered in the medical record together with an explanation of the clinical basis for the requested consultation.

D. If the history and physical are not on the chart, it shall be the responsibility of the physician or authorized APP requesting the consultation to document and provide this information to the consultant.

E. If after discussion with the attending physician or authorized APP, a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse may call this to the attention of his/her superior, who, in turn, may refer the matter to the Vice-President of Patient Care Services, or designee. The Vice-President of Patient Care Services, or designee, may bring the matter to the attention of the chairman of the department in which the physician or authorized APP in question has clinical privileges and the Vice-President of Medical Affairs, and shall notify the attending physician or authorized APP of this action. In all situations that require it, the chairman of the department may request a consultation after appropriate discussion with the attending physician or authorized APP.

SECTION 3. CONTENTS OF CONSULTATION REPORT

Each consultation report should contain a written opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record. A limited statement, such as "I
concur" does not constitute an acceptable consultation report. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record. The consultation report shall contain the date of the consultation and the signature of the consultant.

SECTION 4. SURGICAL CONSULTATIONS

Whenever a consultation is required or ordered prior to surgery, the anesthesiologist shall ascertain that an adequate notation of the consultation, signed by the consultant, appears in the medical record. If it does not so appear, surgery and anesthesia shall not proceed.
CHAPTER IV

SURGICAL CARE

SECTION 1. SCHEDULING SURGERY/PROCEDURES

See OR Scheduling Policy

SECTION 2. CONSENT

The patient shall not go to surgery without an informed consent form signed by the patient or by the patient's designee, and an anesthesia consent form signed by the patient or the patient's designee.

SECTION 3. PERFORMING SURGERY ON FAMILY MEMBERS

Surgeons are discouraged from performing surgery on family members.

SECTION 4. ANESTHESIA

A. Anesthesia shall not be initiated until contact has been made with the operating surgeon and his arrival at the Hospital have been confirmed.
B. The surgeon may be needed to assist or supervise the positioning of the patient and should be available in the event of an emergency.
C. The anesthesiologist shall verify that there has been appropriate laboratory data in the clinical record on all patients referred to him. The pre-anesthesia evaluation must include appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical procedure anticipated.
D. The anesthesiologist shall review the patient’s condition immediately prior to induction of anesthesia.
E. A record shall be maintained of all events taking place during the induction, maintenance and emergence from anesthesia. Postoperative documentation includes at least the following records:
   1. Vital signs and levels of consciousness;
   2. Medications (including intravenous fluids) and blood and blood components;
   3. Any unusual events or postoperative complications, including blood transfusion reactions, and the management of those events; and
   4. The names of providers of direct patient care nursing services, or the names of people who supervised that care if it was provided by someone other than a qualified registered nurse.
F. The findings of a pre-anesthesia examination by an anesthesiologist shall be recorded prior to surgery.
G. Post-anesthesia follow-up assessment will be conducted and documented in the medical
H. Anesthesiologists are discouraged from administering anesthetics to family members.

SECTION 5. PACU ADMISSION AND DISCHARGE REQUIREMENTS

The surgeon or APP with appropriate privileges shall remain in the operating room area until his patient is transferred from the surgical suite. The patient may be discharged from post-sedation or post-anesthesia care by a responsible licensed independent practitioner or by the use of relevant discharge criteria approved by the Medical Staff.

SECTION 6. ADMISSION RESPONSIBILITIES FOR DENTAL OR PODIATRIC PATIENTS

A patient admitted for dental or podiatric surgery is the dual responsibility of the attending dentist or podiatrist and physician.

A. Dentists' and Podiatrists' responsibilities:

1. a detailed dental or podiatric history justifying hospital admission;
2. a detailed description of the examination of the oral cavity or foot and preoperative diagnosis;
3. a complete operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed;
4. progress notes pertinent to the oral or podiatric condition;
5. a clinical summary or statement; and
6. a discharge order.

B. Physicians’ responsibilities:

1. medical history pertinent to the patient's general health;
2. a physical examination to determine the patient's condition prior to anesthesia and surgery; and
3. supervision of the patient's general health status while hospitalized.

SECTION 7. SURGICAL PRIVILEGES

A roster of physicians, dentists and podiatrists currently possessing surgical privileges, with a delineation of the surgical privileges of each shall be available electronically to the surgical suite and operating room supervisor.

SECTION 8. PATHOLOGY REPORT

Ordinarily, tissues or exudates removed during a surgical procedure shall be labeled and sent to the Laboratory for examination by the pathologist. The extent of the examination shall be determined by the pathologist, based on pertinent clinical information, including the source and the preoperative and postoperative diagnosis. The pathologist shall sign his report, which becomes
Certain categories of specimens may, at the surgeon's discretion, be discarded, with documentation of same in the patient's medical record by the surgeon. These specimens include:

1. Specimens unlikely to be productively examinable, such as a cataract or rib removed incidentally at thoracotomy;
2. Traumatically injured members that have been amputated;
3. Fluids, foreign bodies or specimens which are delivered directly to law enforcement representatives in chain of custody;
4. Specimens known to be very rarely pathological and whose absence is readily visible postoperatively, such as the foreskin after circumcision;
5. Grossly normal placentas;
6. Teeth removed as an expected result of the procedure, provided that the anatomic name or number of the teeth or fragments removed are documented in the medical record.

SECTION 9. OBSTETRICAL AND GYNECOLOGICAL SURGERY

A. As defined in the Ethical and Religious Directives for Catholic Health Care Services, abortions and operations for the sole purpose of procuring an elective sterilization shall not be performed in this Hospital.
B. Procedures designed to stop hemorrhage - as distinguished from those designed precisely to expel a living and attached fetus - are permitted, insofar as necessary, even if fetal death is inevitably a side effect.
C. Uterine curettage may be performed following a complete, incomplete or missed abortion. A written statement verifying this, signed by the attending physician, or a confirmatory report by a clinical laboratory must appear in the patient's medical record.
D. Prior to all gynecological procedures on women of childbearing age, the attending physician must make a reasonable effort to rule out unsuspected pregnancy and a notation of said efforts shall be documented in the medical record.
E. Physicians with privileges in newborn resuscitation or the neonatal resuscitation team whose sole responsibility is care for the newborn must be available in the operating room at the time of uterine incision for elective Cesarean Sections.
CHAPTER V

NURSERY AND CARE OF NEWBORN

See Pediatrics Policies and Procedures.

SECTION 1. EXAMINATIONS

All newborn infants delivered at the Hospital shall be admitted to the Hospital and shall have a complete physical examination by a physician or APP with appropriate privileges to make such examinations prior to discharge from the Hospital. Results of the examination shall be recorded in the infant's medical record within twenty-four (24) hours or prior to discharge. An infant who displays abnormal signs and symptoms at any time shall be examined by a physician or APP with appropriate privileges as soon as possible.

SECTION 2. HIGH-RISK INFANTS

The delivering physician shall ensure that a physician appropriately credentialed in high-risk newborn privileges is present at the time of delivery of a potentially high-risk infant, whenever possible.

SECTION 3. PROPHYLACTIC TREATMENT OF NEWBORNS

Parents will be advised of legal requirements for prophylactic treatment of newborns. If the parent or guardian of the newborn child objects, on the grounds that the prophylactic treatment conflicts with the parent's religious beliefs or practices, prophylactic treatment shall be withheld, and an entry in the child's hospital record indicating the reason for withholding treatment shall be made and signed by the attending physician or authorized APP and the parent or guardian.

SECTION 4. CONSULTATIONS

All Family Practice physicians and APPS with obstetrical privileges will obtain OB consultations on high-risk, problem-prone diagnoses/procedures as described in their privilegeform.
CHAPTER VI

MEDICAL RECORDS

SECTION 1. GENERAL RULES

The attending physician or authorized APP will be responsible for preparing timely, complete and legible medical records. The medical record must contain sufficient information to identify the patient, support the diagnosis, justify treatments provided and promote continuity of care among health care providers. Only abbreviations, signs or symbols listed in the approved abbreviation book will be used in the medical record. Administrative Policy #120 lists the prohibited abbreviations.

SECTION 2. AUTHENTICATION

Every medical record entry is dated, timed and signed or authenticated by its author as required by the medical staff bylaws.

SECTION 3. TRAINING IN THE ELECTRONIC HEALTH RECORD

The Medical Staff recognizes the significant advance in using an electronic health record (EHR). The EHR tools allow for greater patient safety and improved quality of care. Training is necessary for the individual physician, Advanced Practice Professional, or LIP in order to fulfill regulatory documentation requirements (CMS and The Joint Commission). All documents are electronic, with remote signage capability. Effective usage of the electronic health record requires training and the informatics staff are available for training. For reasons of patient safety and promotion of clinician competency and efficiency, medical staff leadership has set the following training expectations:

- New physicians and Advanced Practice Professionals are required to receive their EHR training applicable to their area of clinical practice and consistent with their projected scope of practice in the hospital prior to receiving privileges.

SECTION 4. CONTENT

Each medical record contains, as applicable, the following information:

A. The patient's name, sex, address, date of birth, and authorized representative, if any;
B. Legal status of patients receiving behavioral health care services;
C. Documentation and findings of assessments;
D. Conclusions or impressions drawn from medical history and physical examination;
E. The diagnosis, diagnostic impression or conditions;
F. The reason(s) for admission or care, treatment and services;
G. The goals of the treatment and treatment plan;
H. Evidence of known advance directives;
I. Evidence of informed consent when required by hospital policy;
J. Diagnostic and therapeutic orders;
K. All diagnostic and therapeutic procedures, tests and results;
L. Operative or other invasive procedures;
M. Progress notes made by authorized individuals;
N. All reassessments and plan of care revisions, when indicated;
O. Relevant observations;
P. The response to care, treatment and services provided;
Q. Consultation reports;
R. Allergies to foods and medicines;
S. Every medication ordered or prescribed;
T. Every dose of medication administered (including the strength, dose or rate of administration, administration devices used, access site or route, known drug allergies and any adverse drug reaction);
U. Every medication dispensed or prescribed on discharge;
V. All relevant diagnoses/conditions established during the course of care, treatment and services;
W. Records of communication with the patient regarding care, treatment and services, for example, telephone calls or e-mail, if applicable;
X. Patient-generated information (for example, information entered into the record over the web or in pre-visit computer systems), if applicable;
Y. Clinical resumes and discharge summaries, or a final progress note or transfer summary;
Z. Emergency care, treatment and services provided to the patient before his or her arrival, if any; and/or
AA. For emergency room records, time and means of arrival and condition on discharge.

SECTION 5. PROGRESS NOTES

A. Progress notes shall be entered in the medical record by the attending physician or authorized APP, as well as by every other practitioner who examines the patient. Progress notes should give a pertinent chronological report of the patient's course in the Hospital and reflect any change in condition and the results of treatment. Progress notes shall be legible, recorded, timed and dated at the time of observation and shall contain sufficient content to insure continuity of care if the patient is transferred. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Individuals who have been granted clinical privileges and specified professional personnel may also write pertinent progress notes.

B. An immediate postop progress note shall be recorded, timed, dated and signed by the surgeon or proceduralist prior to the patient advancing to the next level of care and shall contain the following documentation elements:

1. Name of the primary surgeon and any and all assistants;
2. Procedure performed;
3. Description of each procedure finding;
4. Estimated blood loss;
5. Specimens removed; and
6. Postoperative Diagnosis;

SECTION 6. OPERATIVE AND HIGH-RISK PROCEDURE NOTES AND REPORTS

A. A detailed operative or other high-risk procedure report must be dictated immediately following the procedures, signed, dated and timed by the surgeon or proceduralist and be available in the patient’s electronic health record as soon as possible thereafter. An operative or other high-risk report shall contain the following documentation elements:

1. Name of the primary surgeon and any and all assistants;
2. Preoperative diagnosis;
3. Names of surgical procedures performed;
4. Description of each procedure;
5. Description of techniques and findings;
6. Type of anesthesia;
7. Complications encountered, if any;
8. Description of specimens removed;
9. Estimated blood loss;
10. Implants and grafts; and
11. Postoperative Diagnosis;

SECTION 7. DISCHARGE SUMMARY/FINAL PROGRESS NOTE

The attending physician or authorized APP has the responsibility to complete the discharge summary as follows:

A. A discharge summary is required for all stays greater than or equal to forty-eight (48) hours and all deaths and transfers. The discharge summary includes:

1. The reason for hospitalization;
2. Significant findings;
3. Procedures performed and care, treatment and services provided;
4. The patient’s condition at discharge; and
5. Instructions to the patient and family.

B. For patients that are hospitalized less than forty-eight (48) hours, and for newborns with uncomplicated deliveries, a discharge summary or discharge progress note will be legibly written or dictated documenting the primary discharge diagnosis, any operative procedures, the patient’s condition at discharge, discharge instructions and follow-up care required.

C. Timeliness – It is preferred that the discharge summary is dictated, signed, dated and timed within seven (7) days of discharge. The discharge summary will be considered delinquent if not dictated and signed, dated and timed within thirty (30) days of discharge.

D. A discharge summary completed by an authorized APP will be counter-signed by their collaborating or sponsoring physician, or their designee.
SECTION 8. FAILURE TO COMPLETE MEDICAL RECORDS

All medical records shall be completed within thirty (30) days of the patient’s discharge.

A. Timeliness of Documentation

1. History and Physical:
   New admissions will be monitored daily for presence of a history and physical;
   a. If a history and physical is not dictated, received from the physician’s or authorized APP’s office or legibly hand-written in the record within twenty-four (24) hours of admission the responsible physician or authorized APP is placed on the Blue Tag list and provided a warning;
   b. If the history and physical is not dictated, received from the physician’s or authorized APP’s office or legibly hand-written in the record within forty-eight (48) hours of admission the responsible physician or authorized APP is placed on the Red Tag list;

   When placed on the Red Tag list, the physician or authorized APP cannot admit any new, non-emergent patients to the hospital, provide non-emergent consultation or schedule new elective cases. The physician or authorized APP will remain on the Red Tag list until the history and physical is dictated. A physician or authorized APP on the Red Tag List is expected to carry out Medical Staff or APP duties while on the Red Tag list, including Emergency Department Call, as appropriate to their staff category. Physicians and/or authorized APPs placed on the Red Tag list will remain on the Red Tag list until the flagged deficiency(ies) are completed.

2. Operative Report:
   Surgical records will be monitored daily for the presence of an operative report.
   a. If an operative report is not on the chart within twenty-four (24) hours of a surgical procedure, the responsible physician will be placed on the Blue Tag list and provided warning;
   b. If the operative report is not dictated within one (1) week of being placed on the Blue Tag list, the physician will be placed on the Red Tag list.

   When placed on the Red Tag list, the physician cannot admit any new, non-emergent patients to the hospital, provide non-emergent consultation or schedule new elective cases. A physician on the Red Tag List is expected to carry out Medical Staff duties while on the Red Tag list, including Emergency Department Call. Physicians placed on the Red Tag list will remain on the Red Tag list until the flagged deficiency(ies) are completed.

3. Discharge Summary:
   a. If the discharge summary is not dictated and signed or authenticated within seven (7) days of discharge, the responsible physician or authorized APP will be notified in writing;
b. If not dictated and signed or authenticated within fourteen (14) days of discharge, the physician or authorized APP will receive a second written notice;

c. If the discharge summary is not dictated and signed or authenticated within twenty-one (21) days of discharge, the responsible physician or authorized APP will be notified in writing and phoned at his or her office and placed on the Blue Tag list;

d. If the physician or authorized APP does not dictate and sign or authenticate the discharge summary within thirty (30) days of discharge the physician or authorized APP will be placed on the Red Tag list.

When placed on the Red Tag list, the physician’s and/or authorized APP’s computer flag for admissions will be turned off and the physician and/or authorized APP will voluntarily suspend his or her privileges to admit any new, non-emergent patients to the hospital, provide non-emergent consultation or schedule new elective cases. A physician and/or authorized APP on the Red Tag List is expected to carry out Medical Staff or APP duties while on the Red Tag list, including Emergency Department Call, as appropriate to their staff category. Physicians and/or authorized APPs placed on the Red Tag list will remain on the Red Tag list until all delinquent records are completed.

B. Notification of Untimeliness:
   Records will be monitored weekly by HIM personnel for compliance. HIM personnel shall review the medical records of all discharged patients to ensure that the record is complete within the applicable time frames identified above.

   If HIM determines that the records are untimely, then a notice shall be issued to the responsible physician and/or authorized APP advising him or her that he or she has been placed on the Blue or Red Tag list, as appropriate, and that his or her clinical privileges are in jeopardy of being, or have been, restricted in accordance with the medical record completion policies. A physician and/or authorized APP is considered delinquent if any portion of a medical record for which he or she is responsible is incomplete more than thirty (30) days after discharge and results in the physician and/or authorized APP being placed on the Red Tag list. A physician and/or authorized APP will have seven (7) days after Red Tag notification to complete and authenticate records. Physicians and/or authorized APPs placed on the Red Tag list shall remain on the Red Tag list until all delinquent records are completed. Any physician and/or authorized APP on the Red Tag list for thirty (30) consecutive days shall be administratively suspended until all records are completed.

C. Extension:
   Physicians and/or authorized APPs whose records cannot be completed within the designated time period after receiving notification should contact HIM staff requesting an extension if there are mitigating circumstances (i.e. vacation, documented illness or technical problems in HIM). Medical records unavailable to physicians and/or authorized APPs at time of their visit to HIM will not be considered delinquent and the completion date will be extended for a period of seven (7) days.

   The Director of Health Information, or his/her designee, will monitor the completion patterns
by physician and authorized APP. Findings will be reported to the Chief Executive Officer, the Medical Executive Committee and Credentials Committee.

D. Methods of Notification:
If monitoring reveals that a given record is incomplete, the responsible physician and/or authorized APP will be notified by phone and in a written notice placed in the physician’s or authorized APP’s box in the physician’s lounge or faxed/mailed (as appropriate).

E. Disciplinary Action:
Any physician or authorized APP who has been on the Red Tag list four (4) times during the preceding 365 days shall be reported to the Chief Executive Officer, the President of the Medical Staff and Medical Executive Committee. If the physician or authorized APP is placed on the Red Tag list two (2) additional times during the subsequent 365 days, he/she shall automatically be placed on probation for 365 days. During any such probationary period, if the physician or authorized APP is on the Red Tag list two (2) additional times, the physician’s or authorized APP’s membership shall be automatically relinquished and the physician or authorized APP shall be required to reapply for membership on the Medical Staff or APP staff.

F. Definitions:
1. “Attending Physician or APP” means the admitting physician or APP or the Medical Staff appointee to whom the admitting physician or APP has transferred responsibility for the patient pursuant to Article I, Section 2 and 3 of the Policy and Plans;
2. “Incomplete Medical Record” means a record that has a flagged dictation or authentication deficiency;
3. “Complete Medical Record” means all required entries and documents are in the record and have been dictated and signed or authenticated within 30 days of discharge.

SECTION 9. POSSESSION, ACCESS AND RELEASE

See Medical Records Policies and Procedures.

A. All medical records are the physical property of the Hospital and shall not be taken from the confines of the Hospital. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

B. All access to patient records will comply with HIPAA Confidentiality and Security Policies.

C. Access to the medical records of all patients shall be afforded to appointees of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Former Staff appointees or APPs shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital. Any publication of compiled data from the Hospital's patients' medical records is forbidden without written approval of the Chief Executive Officer.

D. Written consent of the patient is required for release of medical information to those not otherwise authorized by HIPAA policies to receive this information.
It is the policy of Saint Alphonsus Medical Center-Nampa that a patient or patient representative gives voluntary and informed consent for all care, treatment and services involving material risk.

The purpose of obtaining informed consent is to provide information to the patient regarding his/her health status, diagnosis, prognosis, and appropriate care, treatment and service options. This is a process of information exchange that allows the patient to make an informed choice.

In cases other than an emergency (and certain other limited and clearly defined cases), the patient must receive a clear explanation of his/her health status, diagnosis, prognosis and proposed invasive procedures or of proposed non-invasive procedures that carry a material risk of adverse outcome. The patient must be informed of the possible benefits of care, treatment and services, possibilities of any material risks of side effects of the care, treatment and services, and alternative forms of care, to include refusal of medical or surgical interventions. The patient will be allowed to participate in the development of the plan of care and care after discharge from the Medical Center.
SECTION 1. WHO MAY DISCHARGE

Patients shall be discharged only on order of a physician, or his designee. Should a patient leave the Hospital against medical advice or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the Hospital's release form.

SECTION 2. TRANSFER OF PATIENTS

A patient shall not be transferred to another medical care facility unless prior arrangements for admission to that facility have been made. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

SECTION 3. DISCHARGE OF MINORS AND INCOMPETENT PATIENTS

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, a legal guardian, a person standing in loco parentis or another responsible party, unless otherwise directed by the parent, guardian or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing, and the statement shall become a part of the permanent medical record of the patient.

SECTION 4. DEATH, AUTOPSIES AND CORONER'S CASES

A. In addition to physicians, RN’s may make a determination that death has occurred, as defined in the Pronouncement of Death Nursing Procedure. This information may be relayed by the RN to the physician by telephone, whereupon the physician has the prerogative to conclude that the person is dead.

B. The hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the medical staff (specifically the attending physician or clinical psychologist) of autopsies that the hospital intends to perform.

C. An autopsy may be performed only with proper consent in accordance with state law and Hospital policy. All autopsies shall be performed by the Hospital pathologist or by his designee. Provisional anatomic diagnoses shall be recorded on the medical record within forty-eight (48) hours of completion of the autopsy and the complete protocol shall be made a part of the medical record within thirty (30) days.

D. The Pathologist, or designee, will notify all attending and consulting physicians of the date and time that the hospital-based autopsy or non-coroner autopsies will be performed.

E. As defined in the Hospital’s Organ and Tissue Donation Procurement Policy, physicians will work in cooperation with the Hospital to refer all deaths to donor agencies to determine medical suitability of organs and tissues available for transplant.
F. It is the responsibility of the attending physician, or his alternate, to notify the coroner of any cases considered a coroner's case. The following are classified as coroner's cases in Canyon County:

1. cases of death as a result of violence, whether apparently homicidal, suicidal or accidental;
2. cases of death under suspicious or unknown circumstances; and
3. unattended deaths.
CHAPTER IX

CRITERIA FOR CLINICAL PRIVILEGES

SECTION 1. CRITERIA FOR CLINICAL PRIVILEGES

Criteria for clinical privileges in the Hospital shall be recommended by appropriate Hospital departments and committees as stated in the Medical Staff Bylaws and shall be approved by the Board.

SECTION 2. AVAILABILITY OF CURRENT CRITERIA FOR CLINICAL PRIVILEGES

Criteria for clinical privileges are available in the Medical Staff Office.

SECTION 3. MEDICAL STAFF NEW PRIVILEGES POLICY AND PROCEDURE

A. PURPOSE: To provide a mechanism and define the processes and required elements for developing credentialing criteria for new procedures, new services, or extension of current privileges at Saint Alphonsus Medical Center - Nampa, Inc., for use of new equipment which requires specialized training for safe and competent use, or when procedures are requested that cross specialty boundaries or have traditionally been exercised only by individuals from another specialty/specialties.

A new procedure is defined as any procedure that:
1. Is not currently approved by the Board
2. Is not listed on the delineation of privileges form of the applicable department
3. Involves a new clinical application of existing technology
4. Involves significant use of new technology
5. Will be used by practitioners of a medical specialty or medical staff department other than the specialty or department that has traditionally been granted clinical privileges for the procedure or service.

B. POLICY: It is the policy of Saint Alphonsus Medical Center - Nampa, Inc. that no request for clinical privileges will be processed unless the Board has first determined that the particular service will be offered to patients at Saint Alphonsus Medical Center - Nampa, Inc. and, if deemed necessary, that criteria has been developed.

In the event a request is made for which no criteria have been developed, the practitioner shall be informed that the procedure or service is not currently being performed at the hospital, but that, within a reasonable amount of time, the medical staff and hospital will consider the request, determine whether the procedure or service will be offered, and if so, whether the procedure or service is an extension of current privileges or if criteria are necessary. The request shall be considered using the procedure outlined below.
C. PROCEDURE/GUIDELINES:

New Procedure/Services:
When a practitioner requests privilege(s) for which no criteria have been developed, the following procedure(s) shall be followed:

1. Practitioner shall request privileges for the new procedure, new service, or extension of current privileges, in writing, on a form provided by the Hospital. The request shall include the following:

   a. Name of the procedure or service
   b. Technique of procedure or service
   c. Similarities to and differences from existing procedures or services
   d. What, if any, new or additional equipment is required
   e. A list of training programs attended
   f. Specialty/Subspecialty involved
   g. Standards for granting such privilege(s) from specialty society/board/academy

2. Request shall be forwarded to the next scheduled Credentials Committee, including the documentation and information provided by the Practitioner, as noted in item A1 above.

3. Credentials Committee shall review the request and accompanying documentation and shall determine that the request is an extension of current privileges, or that it is not an extension of current privileges and that criteria need to be developed.

   a. If the request is determined to be an extension of current privileges, no further action is necessary and the practitioner shall be so notified.
   b. If the request is determined NOT to be an extension of current privileges, the Credentials Committee may appoint an ad-hoc committee or refer the issue to an existing Medical Staff Department or Committee for the development of criteria, and the practitioner shall be so notified.

4. When more than one specialty or subspecialty is involved in performing the requested procedure, Credentials Committee will appoint an ad-hoc committee with at least one (1) representative from each specialty/subspecialty involved.

5. The ad-hoc committee or Medical Staff Department will review the request taking into consideration the following:

   a. Current competence and clinical judgment
   b. Professional ethics
   c. Education, training and experience
   d. Participation in continuing education
   e. Use of Hospital facilities
   f. Compliance with Medical Staff Bylaws, and Policy and Plans;

6. The ad-hoc committee or Medical Staff Department shall develop criteria to determine those who are competent to exercise the clinical privilege(s) or decide that no criteria are necessary.
The following guidelines shall be used in development of privileging criteria. (The purpose of these guidelines is to define the training, competence and experience required to perform the requested clinical privilege(s):

a. The type of basic education (degree) required to apply for the privilege(s)
b. Board certification requirements, if any
c. Formal post-graduate training requirements (i.e. residency, fellowship, etc.).
   1) All post-graduate training must take place in a program approved by either the American Medical Association (AMA), American Osteopathic Association (AOA), American Podiatric Medical Association (APMA), or Accreditation Council for Graduate Medical Education (ACGME).
   2) In the case of new procedures, the training required outside of post-graduate programs.
d. The amount of recent practice experience required (within the last 12-24 months).
   1) All practice experience must be sponsored by a training program or hospital facility with a formal quality or peer review program.
e. Whether any continued didactic or hands-on training is required.
f. Number and types of references necessary to evaluate skills, judgment and current clinical competence.
g. Proctoring or monitoring requirements.
h. Requirements to maintain privileges (i.e. number of procedures, CME, etc.) to be provided at time of reappointment.
i. Indications and contraindications
   1) The ad-hoc committee or Medical Staff Department has sixty (60) days to make a report/recommendation to the Credentials Committee.

7. Credentials Committee shall review the report and/or recommended criteria 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.

8. Medical Executive Committee shall review the written recommendation and/or recommended criteria of Credentials Committee and make a written recommendation to the Board.

9. The Board shall review the written recommendation and/or recommended criteria of Medical Executive Committee and make a final decision, taking into consideration the following factors:

a. The community and patient need3
b. The capacity of the Hospital to support the new procedure or service requested, including whether appropriate equipment, space, supplies, trained staff, scheduling and other necessary resources are available.
c. Quality of care issues
d. Patient convenience
e. Reimbursement issues
f. Any other business or patient care objectives of the Hospital which the Board believes are relevant to the disposition of the request.
10. The Board reviews the information and documentation provided by the practitioner and either determines to allow the procedure or service to be performed or determines that the procedure or service shall not be performed at Saint Alphonsus Medical Center – Nampa, Inc.

11. If the Board’s determination is to allow the procedure or service to be performed, the new privileges will be added to the privilege form, along with the recommended criteria, and the practitioner may apply for the privilege(s).

12. If the Board’s determination is not to allow the procedure or service to be performed at the Hospital, the practitioner shall be so notified.

Addendum 1
CLINICAL PRIVILEGE CRITERIA
GUIDELINES

<table>
<thead>
<tr>
<th>General Criteria</th>
<th>Description of Criteria</th>
<th>Required Qualification(s) For Clinical Privilege(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Education (MD, DO)</td>
<td>Degree required to perform the requested privilege(s)</td>
<td></td>
</tr>
<tr>
<td>Board Certification</td>
<td>Specify the Board certification requirements for the requested privilege(s)</td>
<td></td>
</tr>
<tr>
<td>Formal Training</td>
<td>Specify the type and extent of formal training, such as type of residency, fellowship or other training</td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>How much practice experience (within the past 12-24 months) the practitioner must demonstrate</td>
<td></td>
</tr>
<tr>
<td>Continued Training</td>
<td>Continued training requirements and/or didactic or hands-on experience required to maintain privilege(s) if any</td>
<td></td>
</tr>
<tr>
<td>Number and types of references</td>
<td>Specify the number and types of references required to evaluate training, ability, judgment and current clinical competence</td>
<td></td>
</tr>
<tr>
<td>Special Proctoring or Monitoring</td>
<td>Specify any special proctoring or monitoring requirements</td>
<td></td>
</tr>
<tr>
<td>Maintaining Privileges</td>
<td>Specify requirements to maintain privileges (i.e. number of procedures, CME, etc.)</td>
<td></td>
</tr>
<tr>
<td>Indications/Contraindications</td>
<td>Specify Indications/Contraindications of procedure</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 4. POLICY FOR CREDENTIALING/PRIVEGING VOLUNTEER LICENSED INDEPENDENT PRACTITIONER(S) IN THE EVENT OF DISASTER

A. Purpose:
To provide a mechanism for disaster credentialing and granting of privileges to volunteer licensed independent practitioners (LIP’s) in the event of a disaster.

B. Policy:
Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.

Any volunteer licensed independent practitioner providing patient care must be granted disaster privileges by the Chief Executive Officer OR the Medical Staff President (or their designees) prior to providing patient care, even in a disaster situation. (Practitioners who are current members of the Medical Staff at Saint Alphonsus Medical Center - Nampa, Inc. do not need to be granted disaster privileges).

C. Procedure:
The practitioner wishing to obtain disaster privileges must supply the information to the Medical Staff Office as indicated below.

The Medical Staff Office will process all requests for disaster privileges and create and maintain a credentials file in accordance with the Medical Staff Bylaws.

The following information must be available in order to be granted disaster privileges:

1. The practitioner credentialed in a disaster situation shall complete the “Temporary Disaster Privilege Form” (attached) which includes a statement attesting that the information given to the hospital is accurate.

2. The practitioner agrees to be bound by all hospital bylaws, policies and rules, Medical Staff Bylaws Rules and Regulations, and policies, and directives from the department chair, supervising/collaborating physician, or any other hospital or medical staff leader.

3. Volunteers considered to be eligible to act as licensed independent practitioners in the organization must at a minimum present:

   a. A valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport)
   b. A list of current hospital/surgery center affiliations(s) where the practitioner currently holds privileges.

   AND

   c. AT LEAST ONE OF THE FOLLOWING (copied and verified when possible):
      1) A current picture hospital ID card that clearly identifies professional designation
      2) A valid current license to practice
      3) Primary source verification of the license
      4) Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-
VHP), or other recognized state or federal organization or group

5) Identification indicating that the practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances by a federal, state, or municipal entity

6) Identification by current hospital or medical staff member(s) who possess personal knowledge regarding volunteer’s ability to act as a licensed independent practitioner during a disaster

4. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following:

   a. Why primary source verification could not be performed in the required time frame;
   b. Evidence of the licensed independent practitioner’s demonstrated ability to continue to provide adequate care, treatment and services; and
   c. Evidence of attempt to perform primary source verification as soon as possible.

Primary source verification of license would NOT be required if the volunteer practitioner has not provided, care, treatment and service under the disaster privileges policy.

5. The Medical Staff Office will also query the NPDBand the OIG.

6. Any information gathered that is not consistent with that provided by the practitioner will be referred to the Chief Executive Officer or the Medical Staff President (or their designees) who will determine appropriate action.

A practitioner’s disaster privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests that the practitioner is not capable of rendering services in a disaster. Termination of the practitioner’s privileges does not entitle the practitioner to request a hearing or other due process.

7. Once the practitioner obtains approval for disaster privileges, a temporary identification card will be issued. The identification card will state the practitioner's name, specialty and assignment.

8. The medical staff oversees the professional practice of volunteer licensed independent practitioners during a disaster. When feasible, the practitioner will practice under the direction and supervision of a credentialed member of the Medical Staff. The organization will conduct a random review of the volunteer licensed independent practitioner's clinical work following the disaster. Review could include direct observation, mentoring or clinical record review.

9. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer licensed independent practitioner) within 72 hours related to the continuation of the disaster privileges initially granted.
10. Disaster privileges are valid ONLY for the duration of the disaster and will automatically terminate at the end of the need for the practitioner's services.
I certify that the above information is true and correct to the best of my knowledge, information and belief.

I hereby agree to volunteer my medical services to Saint Alphonsus Medical Center - Nampa, Inc. during this disaster situation. I agree to abide by the Medical Staff Bylaws, Policy and Plans and any hospital policies and directives. I understand that the Medical Staff President or Chief Executive Officer will determine when the disaster situation has ended and that my temporary disaster privileges will terminate at that time. I understand that this termination is automatic and does not entitle me to a hearing or other due process.

I authorize Saint Alphonsus Medical Center - Nampa, Inc. to consult with any individual(s) or organization(s) who may have information bearing on my professional qualification, competency, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my professional qualifications and competency to carry out the disaster privileges I am requesting. I authorize all individuals and organizations who are requested to provide such information to Saint Alphonsus Medical Center - Nampa, Inc. or its representative.

I release from any liability, all representatives of Saint Alphonsus Medical Center - Nampa, Inc. and its Medical Staff for their acts performed in good faith and without malice in connection with their evaluation of me and my credentials. I release from any liability, all individuals and organizations who provide information to Saint Alphonsus Medical Center - Nampa, Inc. in good faith and without malice concerning my competency, ethics, character and other qualifications including otherwise privileged or confidential information.

I agree that a photocopy or facsimile of this document with my signature may be accepted by an entity from which such information is sought, with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I certify that of this date, I have no physical, medical or mental condition that would impair rendering care to the patients or meeting medical staff responsibilities outlined. I further attest to having no impairment due to chemical dependency/substance abuse.

Signature of Practitioner ___________________________ Date ______________

Practitioner Name – Please Print ___________________________________________
II. IDENTIFICATION(S) – Photocopy when possible:

1. Valid government-issued photo identification issued by a state or federal agency:
   a. ☐ Driver’s License
   b. ☐ Passport
   c. ☐ Other – must specify: ________________________________

2. AND – AT LEAST ONE OF THE FOLLOWING:
   a. ☐ A valid, current license to practice
   b. ☐ Primary source verification of valid, current license to practice
   c. ☐ A current picture hospital ID card that clearly identifies professional designation
   d. ☐ Identification indicating that the practitioner is a member of a:
      i. ☐ Disaster Medical Assistance Team (DMAT), or
      ii. ☐ Medical Reserve Corps (MRC), or
      iii. ☐ Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or
      iv. ☐ Other recognized state or federal organization or group: (Specify) __________________________
   e. ☐ Identification indicating that the practitioner has been granted authority to render patient care, treatment and services in disaster circumstances by a federal, state or municipal entity.
   f. ☐ Identification by current Hospital or Medical Staff member(s) who possess personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster.
      Name of Identifying Medical Staff Member: ________________________________

Verifications Completed By (Name On Line Above) ________________________________  Date __________________________
### III. LICENSE PRIMARY SOURCE VERIFICATION – To be completed immediately or within 72 hours:

<table>
<thead>
<tr>
<th>License:______________</th>
<th>Date Verified:</th>
<th>Verified By:</th>
<th>Primary Source Verification cannot be completed within 72 hours due to the following extraordinary circumstances:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idaho MD/DO/PA:</td>
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<tr>
<td><a href="http://www.bom.state.id.us">http://www.bom.state.id.us</a></td>
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</tr>
<tr>
<td>Telephone: 208/327-7000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax: 208/327-7005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idaho NP/CNM:</td>
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<td></td>
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</tr>
<tr>
<td><a href="http://www2.idaho.gov/ibn">http://www2.idaho.gov/ibn</a></td>
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</tr>
<tr>
<td>Telephone: 208/334-3110</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax: 208/334-3262</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IV. PRIMARY SOURCE VERIFICATIONS – OTHER THAN LICENSE – To be completed within 72 hours:

<table>
<thead>
<tr>
<th>Hospital Verification:</th>
<th>Verification By:</th>
<th>Verified By:</th>
<th>Primary Source Verification Cannot be completed within 72 hours due to the following extraordinary circumstance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>☐ Telephone</td>
<td>☐ Website</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>☐ Fax</td>
<td>☐ Website</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>☐ Telephone</td>
<td>☐ Website</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>☐ Fax</td>
<td>☐ Website</td>
<td></td>
</tr>
<tr>
<td>NPDB Query: <a href="https://www.npdb-hipdb.hrsa.gov">https://www.npdb-hipdb.hrsa.gov</a></td>
<td>☐ Website</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OIG Check: <a href="http://exclusions.oig.hhs.gov/search">http://exclusions.oig.hhs.gov/search</a></td>
<td>☐ Website</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idaho Excluded Provider Check: <a href="http://www.healthandwelfare.idaho.gov">http://www.healthandwelfare.idaho.gov</a></td>
<td>☐ Website</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Liability Insurance Coverage</td>
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</tr>
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</table>
## V. APPROVALS

<table>
<thead>
<tr>
<th>Chief Executive Officer OR Medical Staff President (or designee):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Approval – Chief Executive Officer (or designee)</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>Signature of Approval – President of Medical Staff (or designee)</td>
</tr>
</tbody>
</table>

## VI. FOLLOWUP:

**TEMPORARY IDBADGE#**

Medical Staff/MLP Collaborating/Supervising Practitioner: ____________________________

## VII. 72 HOURDETERMINATION:

72 Hour Due Date and Time: ____________________________

- [ ] Continuation

Of disaster privileges is authorized as determined by the Hospital’s Emergency Management Plan.

- [ ] Situation no longer exists
- [ ] Credentialing revealed adverse information
SECTION 5. TELEMEDICINE POLICY

A. Policy
   It is the policy of Saint Alphonsus Medical Center - Nampa, Inc. that telemedicine services will be provided at this facility as the Originating Site, a Distant/Originating Site, or a Distant Site in a manner that seeks to ensure a high level of care consistent with commonly accepted quality standards and the standards of care for other hospital services.

B. Purpose
   To establish a mechanism for authorizing telemedicine services at Saint Alphonsus Medical Center - Nampa, Inc..

C. Responsibility
   Personnel in the Medical Staff Office of Saint Alphonsus Medical Center - Nampa, Inc.

D. Definitions
   *Telemedicine*: Telemedicine is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.
   *Originating Site*: Originating Site is the site at which the patient is located or where the equipment is located.
   *Distant site*: Distant Site is the site from which the prescribing or treating services are provided.

E. Privileges and Credentialing
   1. Telemedicine Services for LIP’s Responsible for Care, Treatment and Services Licensed Independent Practitioners (LIPs) who have either total or shared responsibility for patient care, treatment and services through a telemedicine mechanism must be credentialed and privileged, utilizing one of the following mechanisms:
      a. The LIP is fully credentialed and privileged at this facility; or
b. The LIP is privileged at this facility using credentialing information from the Distant Site if the requirements in section E.3., below are met.

2. LIP’s Who Provide Interpretive Services

LIPs providing interpretive services such as official readings of images, tracings OR specimens (e.g. radiologists or pathologists) must do so under one of the following two arrangements:

The LIP is credentialed and privileged, utilizing one of the following mechanisms:

a. The LIP is fully credentialed and privileged at this facility; or

b. The LIP is privileged at this facility using credentialing information from the Distant Site if the requirements in section E.3., below are met.

OR

c. The hospital contracts for the provision of these services by the LIP. These services must be provided consistent with existing hospital and medical staff policies addressing contracted services.

3. In order for the Originating Site to utilize credentialing and privileging information from the Distant Site in credentialing and privileging decisions, the following conditions must be met:

a. The Distant Site must be TJC accredited;

b. The LIP must be privileged at the Distant Site for the services to be provided at the Originating Site; and

c. The Originating Site has evidence of an internal review of the LIP’s performance of these privileges and sends to the Distant Site, information that is useful to assess the LIP’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 about the Distant Site LIP from patients, other LIPs, or staff at the Originating Site.

4. In order for a LIP to be eligible to request telemedicine privileges, the following requirements must be met:

a. The Medical Executive Committee (MEC) has recommended that the scope of telemedicine services provided at this (Originating/Distant Site) hospital and the (Distant Site/Originating Site) hospital include the privileges requested by the LIP. Both the Originating Site MEC and the Distant Site MEC must approve this scope of services.

b. The LIP must concurrently maintain privileges, at a minimum, for the same scope of services at the Distant Site as he or she is requesting at the Originating Site.
5. Requests for telemedicine privileges at the Originating Site will be processed through the established procedure for reviewing and granting privileges at the Originating Site. Information included in the completed LIP application for telemedicine privileges at the Originating Site may be collected in the usual manner or may be collected from the Distant Site.

6. LIPs applying to the Saint Alphonsus Medical Center - Nampa, Inc. Staff for the purpose of providing telemedicine services at this facility, will be required to comply with the Medical Staff Bylaws with the exception of the following:

   a. Article II – Divisions of Medical Staff/Call Coverage
   b. Article III – Part D – Department Meeting Attendance Requirements
   c. Article IV—Part A: Qualifications for Appointment and Continued Membership:
      i. Section 2 (c) Are located close enough to provide timely care for their patients
      ii. Section 4 (c) An agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him by the hospital.
      iii. Section 4 (o) A pledge to provide continuous care for patients in the hospital.
      iv. Section 4 (p) A pledge to participate in the monitoring and evaluation of activities of clinical departments
      v. Section 4 (s) A pledge to pay promptly any applicable Medical Staff dues and assessments.
   d. Article V–Part A: Procedure for Reappointment:
      i. Section 3 (c) Attendance at Medical Staff meetings and participation in staff duties as defined by their staff category.

F. Scope of Services
   Each department utilizing the services of telemedicine LIPs will establish an appropriate privilege list for telemedicine LIPs taking into consideration the limitations associated with the telemedicine equipment.

G. Peer Review and Quality Data
   LIPs providing medical care through telemedicine will be required to submit practitioner specific and associated aggregate data to their department for appointment, advancement, and reappointment to allow the department chair to make a judgment on current clinical competence.

H. Termination
   Suspension, termination or restriction of the contractual, employment or other relationship by which the LIP is providing telemedicine services, or failure to maintain compliance with medical staff and hospital bylaws and policies and procedures shall be considered a voluntary relinquishment of all clinical privileges related to telemedicine, and in the case of LIPs with privileges solely related to telemedicine, considered a voluntary relinquishment of membership and privileges.

SECTION 6. EXPEDITED CREDENTIALING POLICY

A. PURPOSE: To provide a more efficient mechanism for review of requests for new or
renewed medical staff and Advanced Practice Professional applications for membership and privileges without compromising quality of review. “Expedited” credentialing provides an expedited review and approval process if specific, pre-defined, Board approved criteria are met.

Expedited Credentialing is neither a right nor a privilege, and no applicant is automatically entitled to this type of processing. Candidates who do not meet the criteria for Expedited Credentialing will be processed through the usual credentialing process as specified in the Medical Staff Bylaws.

B. PROCEDURE: The Credentials Committee Chair and Medical Staff Coordinator, or their designee, will review each application and its associated documentation, and categorize the application according to the following criteria:

1. Category One - Expedited:
   Category One applications must meet all of the following criteria:

   a. All requested information has been returned promptly;
   b. The application does not contain inaccurate or incomplete information;
   c. The application does not contain unexplained gaps in time;
   d. There are no discrepancies in information received from the applicant or references;
   e. There are no negative or questionable references;
   f. The applicant has completed a normal education/training sequence;
   g. The applicant has an unremarkable medical staff/employment history;
   h. The applicant has submitted a reasonable request for clinical privileges consistent with his/her specialty, and based on experience, training, and competence, and is in compliance with applicable criteria;
   i. Medical staff membership, staff status and/or clinical privileges have never been resigned, denied, revoked, suspended, restricted, reduced, voluntarily or involuntarily surrendered, or not renewed at any other health care facility;
   j. The applicant has never withdrawn application for appointment, reappointment or clinical privileges or resigned from the medical staff before a decision was made by another health care facility's governing board;
   k. The applicant possesses current, valid Idaho license, professional liability insurance (in limits approved by the hospital and with no excluded areas of coverage), and federal and/or state narcotics certificate(s), if applicable;
   l. No license(s), DEA or other controlled substance authorizations, or membership in local, state or national professional societies have ever been suspended, modified, terminated or voluntarily or involuntarily surrendered or are pending;
   m. Specialty board certification or eligibility has never been denied, revoked, relinquished, not renewed, suspended or reduced, nor have proceedings toward those ends been instituted;
   n. The applicant has never been named as a defendant in a criminal action and/or has never been convicted of a crime;
   o. There are no National Practitioner Data Bank entries other than a malpractice history which meets the requirements of subsection p below;
p. The Applicant has not been involved in three (3) or more malpractice claims in the past ten (10) years or any settlements or judgements in the past five (5) years;
q. There are no proposed or actual exclusions and/or any pending investigations of the applicant from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid;
r. The applicant has indicated that he/she can safely and competently exercise the clinical privileges requested, with or without a reasonable accommodation;
s. The applicant’s history shows an ability to relate to others in a harmonious, collegial manner;
t. There is no final recommendation by Medical Executive Committee that is adverse or has limitations;
u. At the time of renewal of privileges, documentation of activity in the hospital and/or verification from outside healthcare entities and/or peers sufficiently verifies current competence;
v. At the time of renewal of privileges, there is no adverse information reported on the reappointment profile.

2. Processing Category One Applications:

a. The Medical Staff Office receives and processes the application.
b. The appropriate department chair and the Credentials Committee Chair, or designees, review the completed and verified application.
c. The Department and Credentials Committee Chair, or designees, forward a report with findings and a recommendation to the Medical Executive Committee, which reviews the application at its next scheduled meeting.
d. The Chief of Staff then forwards the Executive Committee’s recommendation to the Governing Board, which reviews the application at its next scheduled Board meeting.
e. If, at any point, any reviewer feels the application does not meet Category One criteria, the file will be considered Category Two and the usual review process (Category Two) will be followed.
f. An informational report will be made to all members of Credentials Committee at its next regularly scheduled meeting.

3. Category Two - Full Review:

Applications that do not meet ALL requirements as outlined under "Category One" above will be processed and transmitted through the full review process as outlined in the Medical Staff Bylaws.

SECTION 7. CONTINUING MEDICAL EDUCATION

A. All Medical Staff members and others holding delineated clinical privileges are expected to obtain continuing medical education (CME) in order to maintain the expertise in their area of practice and to treat patients in an appropriate fashion.
Practitioners holding delineated clinical privileges will not be required to report CME credits if the following are satisfied:

1. The Idaho State Board of Medicine continues the requirement of 40 hours, every two years, of continuing medical education to renew state licensure; and
2. The practitioner continues to hold a current unrestricted license to practice in the State of Idaho.

B. All current providers holding delineated clinical privileges as of January 1, 2019 who prescribe pharmaceuticals will be required to complete and submit two (2) hours of AMA PRA Category I accredited Opioid education by June 30, 2019. Proof of completion shall be submitted to the Medical Staff Office. All providers who initially come on staff after January 1, 2019 and thereafter will be required to complete and submit the two (2) hours of Opioid education within 6 months of their start date.
SECTION 1. FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICY

A. Initially requested privileges of all new Medical Staff members; and
B. Current Medical Staff members seeking additional privileges or privileges to perform new or rarely performed procedures prior to granting of the privilege to independently perform requested procedures; and
C. When questions arise regarding a practitioner’s professional performance that may affect the provision of safe, high quality patient care.

**Evaluation Period**

The evaluation period for initially requested procedures/admissions of new appointees shall be determined by the appropriate department. If a proctor is assigned, the proctor will continue to act in an advisory capacity to the appointee throughout his/her provisional period.

If, at the end of the provisional period, the proctor is unable to provide an evaluation, the provisional period may be extended by the Credentials Committee.

The evaluation period for new or additional privileges shall be determined by the appropriate department or Credentials Committee on a case by case basis.

**Terms of Evaluation**

Approved evaluation methods may include chart review (both concurrent and retrospective), monitoring clinical practice patterns, direct observation, external peer review, discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel, and may include an evaluation of the physician's ability to work harmoniously with others and interpersonal skills with peers, nursing staff, ancillary personnel and hospital administration.

The terms of evaluation may vary from one department to another (as predetermined by each department) however, procedures crossing specialty lines should have equivalent evaluation requirements. The minimum number of cases/procedures to be reviewed shall not be altered unless modifications, warranted by training and/or experience, are allowed by the department and have been approved by the department chair. Modified proctoring plans shall be submitted to Medical Executive Committee for final approval.

**Duties/Responsibilities of Department Chairs**

Each medical staff department chair shall be responsible for:

1. Assisting the department in establishing a minimum number of cases/procedures to be
evaluated and determining when a proctor must be present. When there are privileges that cross specialty lines, the Credentials Committee shall determine the minimum number of cases/procedures to be reviewed;

2. Identifying the names of proctors.

3. If at any time during a proctoring period, the proctor notifies the department chair that he/she has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), based on the recommendations of the proctor, the department chair shall then review the medical records of the patient(s) treated by the practitioner being proctored and shall:
   a. Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient; or
   b. Refer the case(s) for peer review pursuant to the Peer Review Policy; or
   c. Recommend to Medical Executive Committee that:
      • Additional or revised proctoring requirements be imposed upon the practitioner;
      • Corrective action be undertaken pursuant to the Corrective Action Plan

**Duties/Responsibilities of the Medical Staff Office**

The Medical Staff Office shall:

1. Send a letter to the practitioner being evaluated and to any assigned proctor containing the following information:
   a. Evaluation requirements as predetermined by the department or Credentials Committee;
   b. The name of the practitioner being proctored and the proctor and proctoring forms to be completed; and
   c. A copy of the Focused Professional Practice Evaluation Policy and Procedure

2. Develop a mechanism to track admissions, procedures and/or clinical practice patterns of the practitioner being evaluated;

3. For practitioners being proctored:
   a. Provide information to appropriate hospital departments about practitioners being proctored, including the name of the proctor and a supply of proctoring forms as needed;
   b. Periodically contact both the proctor and practitioner being proctored to ensure that proctoring and chart reviews are being conducted as required;

4. Periodically submit a report to departments and/or Medical Executive Committee of evaluation activity for all practitioners being evaluated; and

5. At the conclusion of the evaluation period, submit a summary report on each practitioner being evaluated to Credentials Committee and Medical Executive Committee.

**Proctoring Procedure**

**Assignment of Proctor:**
The Department Chair will appoint an eligible proctor(s). To the extent possible, the proctor(s) should be qualified and possess credentials similar to the practitioner being proctored.
When the situation exists in which no other physician in that department is qualified or
credentialled to serve as a proctor or a conflict of interest has been declared, a physician with
appropriate privileges from another department may be assigned or an outside proctor may be
retained. An outside proctor may be granted temporary privileges to serve in a proctoring capacity.

Duties/Responsibilities of Practitioners Being Proctored
Practitioners being proctored shall:

1. Notify the proctor of each case where care is to be evaluated and, when required, do so in
   sufficient time to allow the proctor to observe or review concurrently. For elective
   surgical or invasive procedures where direct observation is required, the practitioner must
   secure agreement from the proctor to attend the procedure. In an emergency, the
   practitioner may arrange for proctoring by another member of the Medical Staff with
   appropriate independent privileges or admit and treat the patient; however, the
   practitioner must notify the proctor as soon as reasonably possible;

2. Have the prerogative of requesting from the department chair a change of proctor if
   disagreements with or incomplete proctoring duties by the current proctor may adversely
   affect his or her ability to satisfactorily complete the proctorship. The department chair
   will make a recommendation on this matter to the Medical Executive Committee for final
   action;

3. Inform the proctor of any unusual incident(s) associated with his/her patients;

4. Ensure documentation of the satisfactory completion of his or her proctorship, including
   the completion and delivery of proctorship forms and the summary proctor report to the
   Medical Staff Office. If the proctorship forms and the summary proctor report are not
   completed and submitted at the end of the initial proctoring period, the proctoring period
   will automatically extend for up to three (3) months. Following this automatic extension,
   the Credentials Committee may elect to further extend the proctoring period. If a
   practitioner fails to complete and deliver the proctorship forms and the summary proctor
   report to the Medical Staff Office by the end of a proctoring period extended under this
   subparagraph 4, regardless of the duration of the extension, such failure shall be treated as
   a voluntary relinquishment of the privileges which were subject to proctoring.

Duties/Responsibilities of the Proctor
The proctor shall:

1. As predetermined by the department or Credentials Committee:
   a. Directly observe the procedure being performed, and/or
   b. Concurrently observe medical management for the medical admission;
   c. Retrospectively review the completed medical record following discharge;
   d. Communicate whether a sufficient number of cases performed at Saint Alphonsus
      Health System and/or from another CMS certified organization have been presented
      for review to properly evaluate the clinical privileges requested;
   e. If a sufficient number of cases have NOT been presented for review, whether in the
      proctor's opinion, the proctoring period and/or provisional period should be extended;
   f. If a sufficient number of cases have been presented to properly evaluate the clinical
      privileges requested, a report concerning the qualifications and competence of the
      practitioner being proctored to independently exercise these privileges;
   g. For provisional appointees, make a recommendation for staff status reclassification to
a non-provisional status or recommend an additional proctoring period and/or continued provisional staff status, or NOT recommend advancement or appointment; and

h. For new or additional privileges, make a recommendation to independently perform the requested privileges or recommend an additional proctoring period, or NOT recommend continued clinical privileges as requested.

2. Complete proctoring forms and assure their confidentiality and delivery to the Medical Staff Office;

3. Submit any additional information as necessary in addition to the proctor forms at the conclusion of the proctoring period;

4. If at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the department chair and may recommend that:
   a. The department chair intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient; or
   b. The department chair review the case for possible peer review, pursuant to the Peer Review Policy; or
   c. Additional or revised proctoring requirements be imposed upon the practitioner until the proctor can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored; or
   d. The appointee's continued appointment and clinical privileges be referred to Medical Executive Committee.

**Liability of Proctor**

A practitioner serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the hospital. The proctor shall receive no compensation directly or indirectly from any patient for this service, and he/she shall have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor, or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner. The hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising out of his or her acts or omissions in the role of proctor.

**Completion of Proctorship**

At the end of the proctoring period, the proctor shall provide a summary report or response via email to the FPPE personnel in the medical staff office as approval for completion of the FPPE process and advancement from provisional status. This will then go to the Credentials Committee for final approval and advancement.

**FPPE for Physician Performance Issues**

Focused Professional Practice Evaluation shall be conducted when questions arise regarding a practitioner’s professional performance that may affect the provision of safe, high quality patient care which have been identified through the peer review process, ongoing feedback reports or pursuant to the Corrective Action Plan.
Triggers that may initiate this process include but are not limited to:

- Significant deviation from accepted standards of practice;
- Adverse or negative performance trends;
- Repeated failure to follow hospital policy;
- Significant staff or patient complaint(s); and/or
- Upon recommendation of the Department Chair pursuant to Section IV.B. of the Peer Review Policy.

The determination to assign a period of focused monitoring should be based on the practitioner’s current clinical competence, practice behavior and ability to perform the privileges which are at issue. Other existing privileges in good standing should not be affected by this decision.

The terms, methods and duration of the evaluation period shall be determined by Medical Executive Committee.

SECTION 2. MEDICAL STAFF FOCUSED REVIEW AND OPPE

Purpose

To provide an educational, proactive process to support efforts to identify, track, and resolve clinical performance, utilization, corporate compliance and medical error issues in an effort to increase patient safety and the quality of care at Saint Alphonsus Medical Center - Nampa. The Medical Staff has a leadership role in Hospital performance improvement activities.

Policy

It is the policy of Saint Alphonsus Medical Center - Nampa to have a Focused Review of Practitioner Performance (peer review) and Ongoing Professional Practice Evaluation process that facilitates the review of the performance, skill, technique, competence, utilization, and corporate compliance of other medical staff in an objective, impartial, accurate and informed manner that is without conflict of interest or personal issue.

Confidentiality, Immunity, and Compliance with State Law

A. All written records of interviews, reports, statements, minutes, memoranda, and all physical materials related to research, discipline or medical study utilized in the course of the Focused Review of Practitioner Performance and Ongoing Professional Practice Evaluation activities described in this policy and procedure shall be the property of Saint Alphonsus Medical Center Nampa and shall be confidential to the full extent provided by Idaho state law, including, but not limited to, Idaho Code Section 39-1392.

B. Participants in the Focused Review of Practitioner Performance and Ongoing Professional Practice Review activities described in this policy and procedure who furnish information or opinions related to research, discipline or medical study shall be granted immunity from liability to the full extent provided by Idaho state law, including, but not limited to, Idaho Code Section 39-1392.

C. This policy and procedure is intended to comply with the requirements of Idaho Code Section 39-1392f for the organization of in-hospital medical staff Focused Review of
Practitioner Performance committees.
D. Unauthorized disclosure of Department, Committee or legal information designated as confidential may result in disciplinary action or termination for Hospital employees and/or disciplinary action according to the Corrective Action Process outlined in the Medical Staff Bylaws for physicians.

Procedure
A. There are six standard general competencies included in the concurrent and continuous monitoring of members of the medical staff which include:

1. Patient care
2. Medical/clinical knowledge
3. Practice based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. System-based practice

B. The performance dimensions for review to address the above competencies may include:

1. Technical quality and knowledge: Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted
2. Service quality: Ability to meet the customer service needs of patients and other caregivers
3. Patient safety and rights: Cooperation with patient safety and patient rights, rules, and procedures
4. Resource use: Effective and efficient use of hospital clinical resources
5. Relations: Interpersonal interactions with colleagues, hospital staff, and patients
6. Citizenship: Participation in and cooperation with medical staff responsibilities

C. In addition to the hospital performance activities, each medical staff department within Saint Alphonsus Medical Center Nampa will identify rate-based or rule-based performance indicators used for ongoing surveillance and the thresholds for indicators prompting further review (see Addendum 2A).

1. Ongoing Professional Practice Evaluation is conducted via aggregate data by the individual practitioner and compared to the available benchmarks.
2. Ongoing feedback reports are provided to the Medical Staff more often than every twelve (12) months and at the time of reappointment for inclusion in the practitioner’s reappointment profile.
3. The reports are initially analyzed by the Physician Advisor for triggers and adverse trends. Findings and subsequent action, if applicable, are discussed by the Medical Staff Quality Committee (MSQC). The MSQC may provide recommendations to the Medical Executive Committee (MEC) when further intervention is needed (see Exhibit B).

D. Medical Staff Quality Committee (MSQC)
The MEC establishes an independent multi-specialty sub-committee, the MSQC, for the purpose of Focused Review of Practitioner Performance and review of Ongoing Professional Practice Evaluations. The members of the MSQC are the Vice Chairs, or a designee of the Medical Staff Departments, and a Physician Advisor.

1. The MSQC conducts peer review, examines utilization review and corporate compliance issues, and analyzes adverse patterns and trends identified in ongoing performance feedback reports.
2. The MSQC assigns a final case rating (see Addendum 2B) to categorize particular events or types of quality concerns in order to provide guidance regarding quality of physician care to the MEC.

Criteria for Reviews
Focused Review of Practitioner Performance may be initiated due to:
- Significant deviation from accepted standards of practice
- Adverse or negative performance trends
- Repeated failure to follow hospital policy
- Significant staff or patient complaint(s)
- Upon recommendation of the Department Chair

A. When an alleged concern involving a physician comes to the attention of the Quality Management Department:
1. The Quality Management Department, in conjunction with the Physician Advisor, will gather information required to substantiate the concern or allegation. In the event the concern regards the Physician Advisor, the case will be referred to the Chief of Staff.
2. An external review of the case may be considered if there are any potential conflicts of interest.
3. The concern should be evaluated against the sentinel event criteria in the Sentinel Event/Near Miss Policy. If the sentinel event criteria are met, the concern should be reported to the Risk Manager and Vice President of Patient Care Services.
4. Substantiated concerns will be presented to the MSQC to be assigned a final case rating and to determine any recommendations for improvement. Options for further intervention may include, but are not limited to Focused Professional Practice Evaluation (conducted in accordance with the Medical Staff Focused Professional Practice Evaluation Policy); documented discussion; outside review; education; or continued monitoring, proctoring and/or referral for corrective action as outlined in the Medical Staff Bylaws Corrective Action Plan.
5. The involved physician will be notified when a case is under review and will have an opportunity to provide relevant information or comment in writing as determined appropriate by the reviewer(s).
6. In general, the process should be completed within one hundred twenty (120) days.

B. Reporting
1. Any reporting and disciplinary action resulting from a Focused Review of Practitioner Performance shall be undertaken in accordance with the applicable Saint Alphonsus
Medical Center Nampa Medical Staff Bylaws.

2. Aggregate findings should be reported to the MEC and may be reported to Credentialing and the Board.

3. Documents shall be maintained securely and confidentially in the Quality Department, Risk Management, or Medical Staff Office.

4. Any adverse recommendation that is reportable will follow the process outlined by the National Practitioner Data Bank. (See Exhibit A)

Definitions

Focused Review of Practitioner Performance has been renamed by The Joint Commission. It was previously termed “peer review” and now is currently termed Focused Evaluation of Professional Practice. The organization's current process must include the criteria to be used for identified performance issues and defined triggers that indicate the need for performance monitoring.

Focused Professional Practice Evaluation (FPPE) is an established process to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of performing the requested privilege. This process may also be used when a question arises regarding a currently privileged practitioner’s ability to provide quality care. FPPE is a time limited period process to help evaluate a practitioner professional performance.

Ongoing Professional Practice Evaluation (OPPE) is a continual process to identify professional practice trends that may require intervention by the Medical Staff. Key quality indicators drive the Focused Review of Practitioner Performance (peer review) process and are developed, approved and changed as necessary through a joint process involving the Medical Staff Departments, Medical Staff Quality Committee, Medical Executive Committee, and the Hospital.

ADDENDUM 2A:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trigger</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Readmission Within 30 Days of Discharge</td>
<td>Defined by Trinity</td>
</tr>
<tr>
<td>Number of cases referred to Peer Review</td>
<td>3 or more</td>
</tr>
<tr>
<td>Peer Reviewed Cases Assigned a Final Case Rating Controversial Care (3) or Unacceptable Care (4)</td>
<td>2 or more</td>
</tr>
<tr>
<td>Unexpected Death (Expired within 24 hours of admission; expired within 48 hours of anesthesia; patient was intrapartum, neonatal, pediatric, or maternal; was a coroner or medical examiner case; if patient is less than 50 years of age an did not have a DNR or terminal illness)</td>
<td>More than 10% of the specialty average</td>
</tr>
<tr>
<td><strong>Medical/Clinical Knowledge</strong></td>
<td></td>
</tr>
<tr>
<td>Appropriate Blood Usage</td>
<td>TBD</td>
</tr>
</tbody>
</table>
### Interpersonal and Communications Skills

| Complaints Involving Physician Behavior | 3 or more |

### Practiced Based Learning and Improvement

| Core Measure Scores | Defined by Trinity |
| Core Measure Misses  | 2 or more          |
| Adverse events related to moderate or deep sedation | 2 or more |

**Department Specific Indicators**

| *Defined by departments* |

### Professionalism

| Suspension Due to Delinquent Records | 1 or more |
|  | 3 or more |

### System Based (2 charts audited per practitioner)

| H&P Not Completed Within 24 Hours | 1 or more |
| Orders Not Dated and Timed       | 1 or more |
| Illegible Orders                 | 1 or more |
| Use of Unapproved Abbreviations  | 1 or more |

### ADDENDUM 2B:

**Focused Review of Practitioner Performance Final Case Ratings**

- Acceptable Care
- Acceptable Care with Education
- Controversial Care
- Unacceptable Care
- Not practitioner related

**Note**

Controversial Care and Unacceptable Care are reviewed at MSQC and discussed with the Vice Chairs of the Departments for review at the next Medical Staff Department meeting.
Exhibit A: Focused Review of Practitioner Performance Process

Concern for review identified through various sources

Physician Advisor, in conjunction with the Quality Management Department, reviews the concern

Concern Substantiated?

No

Provider is notified of findings. Referral and summary are documented and filed.

Yes

Physician Advisor takes findings to the Medical Staff Quality Committee (MSQC).

Provider is notified of findings. Referral and summary are documented and filed.

Committee determines care or documentation appropriate?

Yes

Unable to determine. Request for response sent to provider. The case and response are reviewed by the MSQC. If a response is not received within 30 days, the case will be assigned a code by the committee with the information available.

No

Case assigned a Code II: Care appropriate, documentation issue.

Case assigned a Code III: Care not appropriate, no adverse outcome.

Case assigned a Code IV: Care not appropriate, adverse outcome.

The provider is notified of findings.

Referral and summary are documented in the provider’s file. Summary of findings and any recommendations by the MSQC may be reported to the Medical Executive Committee (MEC), the Board, and Credentialing.
Exhibit B: Ongoing Professional Practice Evaluation (OPPE) Process

Medical Staff drafts and approves Focus Review of Practitioner Performance (Peer Review) policy and procedure.

Each department identifies performance measures and sets threshold criteria for acceptable/

Quality Management Department works with Medical Staff Departments to identify data elements to support performance measures.

Physician Advisor reviews individual practitioner data on an ongoing basis, at least annually and at reappointment.

Outcomes acceptable?

Yes

Return completed evaluations to Medical Staff Office.

No

Physician Advisor takes findings to the Medical Staff Quality Committee. Recommendations by the MSQC may include a period of Focused Professional Practice Evaluation (FPPE).

A summary of results are presented at Medical Executive Committee (MEC), the Board, and Credentialing.
SECTION 1. COLLEGIAL INTERVENTION POLICY

It shall be the responsibility of each appointee to the Medical Staff to report, in writing, to the President of the Medical Staff or the Chief Executive Officer any conduct, acts or omissions by appointees to the Medical Staff of which he is aware which he, in good conscience, believes to be detrimental to the health or safety of patients or to the proper functioning of the Hospital, or which violate professional ethics.

In advance of making such report, the appointee who has concern about another appointee’s conduct, acts or omissions may advise the other appointee of his concern before such conduct, acts or omissions become a pattern of behavior or practice or rise to a level of being detrimental to the health or safety of patients or the proper functioning of the Hospital. All communications, including oral communications and written reports, made pursuant to this Section shall be confidential to the full extent provided by Idaho State Law, including but not limited to, Idaho Code Section 39-1392.

SECTION 2. CONDUCT

Purpose and Philosophy Statement

It is the policy of the Saint Alphonsus Medical Center-Nampa 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 Medical Center-Nampa ("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.

Definitions

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:

- Submission to or rejection of such conduct is either implicitly or explicitly made a term or condition of employment or participation in Hospital activities.
- Submission to or rejection of such conduct by an individual is used as a basis for evaluation in making personnel decisions affecting an individual.
• Conduct unreasonably interferes with the performance or work of the individual or creates an intimidating, hostile or offensive work environment.

Disruptive Conduct: For purposes of this policy, disruptive conduct includes, but is not limited to, any of the following:

- 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).
- Making degrading, demeaning or insulting comments regarding patients, nursing staff, other Hospital personnel or the Hospital.
- Using profanity, racial slurs or similarly offensive language.
- 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.
- 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).
- 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.

Scope of Policy

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.

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.

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.)

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.

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 Hospital’s event reporting system (e.g., VOICE or its successor). 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 to verify basic information. Complaints which require further review and investigation will initially be evaluated and triaged by a committee composed of the Vice President of Medical Affairs, Vice President of Quality and Patient Safety and/or a representative from the Office of Medical Affairs (“OMA”), the President of the Medical Staff, 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:
- 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 MEC.
• Any reports/complaints of egregious behavior or behavior that appears to be a danger to patients or staff, no matter the frequency of the complaints against the Practitioner, are referred to OMA for distribution to the President and President-elect of the Medical Staff, the Vice President of Medical Affairs, Vice President of 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.

D. Practitioner Notification.

The President of the Medical Staff, or designee, 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.

E. Further Evaluation of Report/Complaint

1. Referral to the MEC 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 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.

   a. 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.

   b. 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 MEC or another appropriate investigator(s) (“Investigator”) to complete a review of the report/complaint and/or 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.
c. Risk Management, the Event Report Triage Committee 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 by designated members of the
ERTC).

2. 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.


a. The Investigator(s) will conduct a 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.

b. 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.

c. 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 ERTC. The Investigator may also be asked to meet
with the Medical Staff President or ERTC members to answer questions regarding the
report and conclusions.

d. 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 ERTC and the matter will proceed as outlined in Section F Below.

e. 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 ERTC
will be so advised and the Complainant and the Practitioner will be notified in writing
by the Medical Staff President. If there is information which may indicate that other
policies have been violated, then the ERTC will make a referral for further
investigation and action to other appropriate Medical Staff or Hospital bodies.

F. 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 MEC and any other appropriate individuals invited by the Medical Staff President.

2. The Medical Staff President 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 J below. If the Practitioner does not present additional information which convinces the majority of the MEC members present that he or she did not violate this policy, the Practitioner will be informed by the Medical Staff President of this conclusion. He or she will also be informed of the remedial action which will be imposed (unless the MEC needs to undertake further deliberation regarding the matter). The MEC will write a formal notification to the Practitioner. In The final findings and written notification to the Practitioner by the Medical Staff President 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 Medical Staff President'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 Medical Staff President 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, Vice President of Medical Affairs, Vice President Quality and Patient Safety and the Hospital CEO should be copied on the final notification to the Practitioner and the Complainant.

G. Remedial Options for Policy Violations

1. Remedial Measures. If the majority of the MEC members who have reviewed the investigative report decide that the Practitioner who is subject of the investigation has violated this policy, the MEC 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.
a. Verbal Warning. Requiring that the Practitioner cease the conduct which gave rise to the complaint.
b. Written Warning. Letters of admonishment, reprimand or warning, requiring that the Practitioner cease the conduct that gave rise to the complaint.
c. Suspension: Suspension for one (1) to fourteen (14) days of all or a portion of the clinical privileges of the Practitioner.
d. 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 MEC.

2. 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.

H. 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).

I. 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 MEC).
- 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.

J. Reappointment

The duration of reappointment may be shortened in order to complete assessment or
invasion 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 3. POLICY ON ASSISTING THE IMPAIRED LICENSED INDEPENDENT PRACTITIONER

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

Definitions
Impairment. For the purpose of this policy, “impairment” is defined as a condition that adversely affects the ability of a Licensed Independent 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.”

Medical Staff. For the purpose of this policy, “Medical Staff” means all physicians, oral and maxillofacial surgeons, dentists and podiatrists who are given privileges to treat patients in the Hospital;

Licensed Independent Practitioner. For the purpose of this policy, “Licensed Independent Practitioner” means all physicians, oral and maxillofacial surgeons, dentists, podiatrists, Medical Associates and Advanced Practice Professionals who are given privileges to treat patients in the Hospital;

Chief of Staff. For the purpose of this policy, the “Chief of Staff” is the President of the Medical Staff, the Acting President of the Medical Staff, or a member of the Medical Staff appointed by the President or the Acting President of the Medical Staff to act on his/her behalf to carry out the duties of the Chief of Staff as set forth in this policy.

Chief Executive Officer. For the purpose of this policy, the “Chief Executive Officer” is the Chief Executive Officer of the Hospital or an individual designated by the Chief Executive Officer to act on his/her behalf to carry out the duties of the Chief Executive Officer as set forth in this policy.
Well-Being Committee. For the purpose of this policy, the “Well-Being Committee” means the Well-Being Committee referred to in the Medical Staff Bylaws.

A. Self-Referral
Any Licensed Independent Practitioner who has reason to believe that he or she is impaired may provide an oral or written report to the Chief of Staff, the chairperson of the self-referring member’s department or the Vice President of Patient Care Services. The recipient of the report shall inform the Chief Executive Officer that a report has been filed. The Chief of Staff and/or the Chief Executive Officer or their designee shall promptly meet with the self-referring member to assist the self-referring member in the location of appropriate professional internal or external resources for diagnosis and treatment of the condition or impairment.

B. Report and Investigation

Scope of Policy
This policy and procedure shall be used to address concerns that a Licensed Independent Practitioner is impaired. All such concerns shall be handled in the manner described below. In the event of any apparent or actual conflict between this policy and the Medical Staff Bylaws, Policy & Plans, or other policies of the Hospital and its Medical Staff (including the due process sections of those Bylaws and policies), the provisions of this policy shall control.

Procedure
1. Report.
   If an individual has a reasonable suspicion that a Licensed Independent Practitioner is impaired, such person shall provide an oral or, preferably, a written, report to the Chief of Staff, the chairperson of the Licensed Independent Practitioner’s department or the Vice President of Patient Care Services. The report does not have to include conclusive proof of impairment, but shall include a factual description of the incident(s) that led to the individual’s concern. The recipient of the report shall inform the Chief Executive Officer and the Chief of Staff that a report has been filed.
   Upon receiving such a report, the Chief of Staff shall promptly advise the member, in writing, that a report has been filed.

2. Initial Evaluation.
   After receipt of a report concerning a Licensed Independent Practitioner’s potential impairment, the Chief of Staff, in consultation with the Chief Executive Officer, or their designees, shall evaluate whether it appears there is sufficient evidence to warrant further investigation of the report. If so, the Chief of Staff or his or her designee may:
   a. Meet personally with the Licensed Independent Practitioner;
   b. Give the Licensed Independent Practitioner an opportunity to make aself-referral pursuant to Section A above; and/or
   c. Direct in writing that an investigation be instituted and a report and recommendation
be rendered by the Well-Being Committee.

3. Investigation.
The Well-Being Committee’s investigation concerning a Practitioner’s impairment may include, but is not limited to, the following:

a. An interview with the Licensed Independent Practitioner;
b. The review of any and all documents or other materials relevant to the Licensed Independent Practitioner’s potential impairment;
c. Interviews with any and all persons involved in the incident(s) that raised concerns regarding potential impairment or other persons who may have information relevant to concerns regarding potential impairment, provided that any specific inquiries made are related to the Licensed Independent Practitioner’s duties and privileges, and that utmost confidentiality is maintained;
d. The requirement that the Licensed Independent Practitioner undergo a complete medical examination (including a psychiatric evaluation, if appropriate) as directed by the Chief of Staff, the chairperson of the Licensed Independent Practitioner’s department, or the Vice President of Patient Care Services, provided the exam is related to the performance of the Licensed Independent Practitioner’s duties and privileges; and

e. A requirement that the Licensed Independent Practitioner submit to an alcohol or drug-screening test (if appropriate to the potential impairment), as permitted by the Idaho Code.

If the Well-Being Committee’s investigation produces sufficient evidence that the Licensed Independent Practitioner is impaired, the Well-Being Committee, in consultation with legal counsel, shall determine the nature of the impairment and whether it is classified as a disability under the ADA. If the Licensed Independent Practitioner’s impairment is classified as a disability under the ADA, such impairment will be subject to the provisions of Section C of this Policy. If the Licensed Independent Practitioner’s impairment is not classified as a disability under the ADA, such impairment will be subject to the provisions of Section D of this Policy.

5. Recommendation.
The Well-Being Committee will evaluate the information gathered during its investigation and recommend action to the Executive Committee, in accordance with this policy, the Medical Staff Bylaws, and applicable law. The Well-Being Committee’s recommendation may include the Licensed Independent Practitioner’s participation in an appropriate rehabilitation program as discussed in Section E of this policy.

The recipient of the initial report shall inform the person who filed the report that the Hospital investigated and acted upon the report. The Licensed Independent Practitioner shall be informed of the results of the investigation by the Well-Being Committee.
7. Confidentiality/Documentation of Investigation.

   a. The Hospital’s investigation and evaluation of a Licensed Independent Practitioner’s potential impairment shall be confidential and shall be conducted pursuant to the Idaho Peer Review Statute, Idaho Code Section 39-1392, et seq. All participants in the investigation shall refrain from discussing the investigation with anyone outside of the process described in this policy.

   b. The report of potential impairment and the Well-Being Committee’s recommendation shall be included in the Licensed Independent Practitioner’s confidential file. The Licensed Independent Practitioner who is the subject of any such report may also submit a written report which shall be included with the report of potential impairment and the recommendation of the Well-Being Committee in the Licensed Independent Practitioner’s confidential file.

8. No Abuse of Policy.

Any Hospital employee or Licensed Independent Practitioner who fabricates allegations of a Licensed Independent Practitioner’s potential impairment shall be subject to appropriate disciplinary action, up to and including termination of employment (for Hospital employees) or corrective action or procedural action (for Licensed Independent Practitioners).

C. Impairments Classified as a Disability Under the ADA

   1. Applicability.
      If a Licensed Independent Practitioner’s impairment is classified as a disability under the ADA, such impairment will be subject to the provisions of this Section C.

   2. Reasonable Accommodation.
      The Well-Being Committee, in consultation with legal counsel, will make a determination as to the following:

      a. Whether the Hospital is able to make a reasonable accommodation that would enable the Licensed Independent Practitioner to competently and safely perform his/her clinical privileges and the duties and responsibilities of his/her appointment;

      b. 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

      c. Whether the impairment constitutes a “direct threat” to the health or safety of the Licensed Independent 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 Licensed Independent Practitioner appears to pose a direct threat because of his/her impairment, the Well-Being Committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level through a reasonable accommodation.

   3. Voluntary Agreement.
If the Hospital is able to make a reasonable accommodation as described above, the Hospital will attempt to work out a voluntary agreement with the Licensed Independent Practitioner, so long as the arrangement would neither constitute an undue hardship upon the Hospital nor create a direct threat as described above. Any voluntary agreement must be submitted to the Executive Committee and be approved by the Chief Executive Officer before it becomes final and effective.

4. Other Recommendation.
If the Hospital is unable to make a reasonable accommodation, or if a voluntary agreement cannot be reached between the Hospital and the Licensed Independent Practitioner in accordance with this policy, the Medical Staff Bylaws, and applicable law, the Well-Being Committee shall recommend action to the Executive Committee. If the Well-Being Committee’s recommendation entitles the Licensed Independent Practitioner to a hearing under the Medical Staff Bylaws, the Executive Committee shall promptly notify the Licensed Independent Practitioner of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Chief Executive Officer or the Board until the Licensed Independent Practitioner has exercised or has been deemed to have waived the right to a hearing as provided in the Medical Staff Bylaws.

D. Impairments Not Classified as a Disability Under the ADA

1. Applicability.
If a Licensed Independent Practitioner’s impairment is not classified as a disability under the ADA, such impairment will be subject to the provisions of this Section D.

2. Recommendation.
Depending upon the nature and severity of the Licensed Independent Practitioner’s impairment, the Well-Being Committee’s recommendation may include, but is not limited to, any of the following:

a. If the Licensed Independent Practitioner affirms the existence of the impairment and agrees to fully cooperate and comply with an appropriate course of rehabilitation, the Licensed Independent Practitioner may be placed on a medical leave of absence for purposes of participation in an appropriate rehabilitation program, subject to the provisions of Section E below and the procedure and approval required by the Medical Staff Bylaws for a leave of absence;

b. If the Licensed Independent Practitioner either denies the existence of an impairment or fails to fully cooperate with or fails to complete the required course of rehabilitation, the Well-Being Committee shall recommend action to the Executive Committee. If the Well-Being Committee’s recommendation entitles the Licensed Independent Practitioner to a hearing under the Medical Staff Bylaws, the Executive Committee shall promptly notify the Licensed Independent Practitioner of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Chief Executive Officer or the Board until the Licensed Independent Practitioner has exercised or has been deemed to have waived the right to a hearing as provided in the Medical Staff Bylaws.

c. If grounds for precautionary review rights or precautionary suspension under the
Medical Staff Bylaws are satisfied, precautionary suspension shall be imposed.

E. Rehabilitation and Reinstatement

1. Rehabilitation.
   If appropriate based on the nature of the impairment, an impaired Licensed Independent Practitioner shall be referred to the IMA Practitioner Recovery Network ("PRN"), which shall assist the Licensed Independent Practitioner in locating a suitable rehabilitation program. The Licensed Independent Practitioner may be placed on a medical leave for purposes of participation in the program subject to the procedure and approval required by the Medical Staff Bylaws for a leave of absence.

2. Eligibility for Reinstatement.
   Upon sufficient proof that an impaired Licensed Independent Practitioner has successfully completed a PRN sanctioned rehabilitation program, the Hospital, at its discretion, may consider the Licensed Independent 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 Licensed Independent Practitioner was treated confirming that:

   a. The Licensed Independent Practitioner participated in the rehabilitation program;
   b. The Licensed Independent Practitioner is in compliance with all of the terms of the program;
   c. Whether, in the director's opinion, the Licensed Independent Practitioner is capable of resuming medical practice and providing continuous, competent care to patients; and
   d. Whether, in the opinion of the director, the Licensed Independent Practitioner should participate in an aftercare program.

3. Reinstatement.
   In considering an impaired Licensed Independent Practitioner’s eligibility for reinstatement, the Hospital must make a decision that is in the best interest of patient care. If all of the information received by the Hospital indicates that the impaired Licensed Independent Practitioner is rehabilitated and capable of resuming patient care, the Hospital shall take the following additional precautions when restoring clinical privileges:

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

4. Aftercare Programs/Monitoring.
Any aftercare programs and/or monitoring will be coordinated by the PRN based on the aftercare program prescribed by the director of the rehabilitation program. In order to ensure appropriate aftercare treatment, the impaired Licensed Independent Practitioner will be required to sign and comply with an aftercare contract with the PRN.
CHAPTER XII

MISCELLANEOUS

SECTION 1. DISASTERS

Physicians are required to respond to disasters as outlined in the Hospital Emergency Preparedness Plan.

SECTION 2. RESEARCH ACTIVITIES

A. Participation in research projects by Medical Staff appointees is encouraged. To ensure adequate compliance with any applicable guidelines and laws, Medical Staff appointees shall consult with and obtain the approval of the Chief Executive Officer regarding any research projects in which they propose to participate.

B. Policy considerations pertaining to medical and/or scientific research projects of the Medical Staff shall be reviewed by the Executive Committee and by the Chief Executive Officer.

C. The results of all research projects, clinical, statistical or otherwise, and all publications written or provided by Medical Staff appointees using the name of this Hospital, must be submitted to the Chief Executive Officer for approval prior to any publication.

D. As defined in the Institutional Review Board Policy, specific protocols are to be followed and specific consents are to be obtained in cases where any investigational pharmaceuticals or medical devices are to be used. Such protocols and consents are to be submitted to the Institutional Review Board for approval and renewal.

SECTION 3. ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)

The Hospital, Members of the Medical Staff and Practitioners with clinical privileges at the Hospital are required to comply with the provisions of the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy and Security Rule relating to the use and disclosure of individually identifiable health information. The Hospital is an integrated health care setting in which the individual receives treatment from not only Hospital personnel but also Members of the Medical Staff and other Non-Member Practitioners with clinical privileges (“Practitioners”). The Hospital, Members of the Medical Staff and Practitioners operate under an Organized Health Care Arrangement or “OHCA” as permitted under HIPAA to facilitate the use and disclosure of individually identifiable health information in order to provide for efficient delivery of quality health care services.

A. Participants.
   The participants are the Hospital and Members of the Medical Staff and Practitioners at the Hospital.

B. Hospital.
   The Hospital consists of the following locations: Saint Alphonsus Medical Center and Saint Alphonsus Nampa Health Plaza.

C. Scope of OHCA activities.
   The scope of the OHCA between the Hospital, Members of the Medical Staff (“Member”) and Practitioners is limited to the locations in (b) above. The OHCA and these Policy and Plans do not apply to:
1. The Member or Practitioner’s independent professional services or individual practice’s privacy practices. (For example, the OHCA does not apply to the Member’s office practice’s use and disclosure of its individually identifiable health information that is maintained by the Member’s office for treatment, payment and operations).

2. Activities unrelated to Privacy Practices. The rule does not imply joint and several responsibilities between Hospital, the Member or Practitioner for the provision of clinical services. The Member or Practitioner is an independent provider of clinical services and these policy and plans do not alter in any way the independent status of the individual.

D. Notice of Privacy Practices:
The Hospital’s Notice of Privacy Practices described the OHCA, its participants, and serves as the OHCA’s Notice of Privacy Practices. The Notices of Privacy Practices govern the information practices that the Hospital, Members of the Medical Staff, and Practitioners agree to comply with for the provision of services to the individual while at the Hospital. The Hospital will be responsible for furnishing the individual with the Notice of Privacy Practices and to obtain the individual’s written acknowledgement of receipt.

E. Records and Designated Record Sets:
The Hospital’s HIPAA Compliance Plan will determine which records are included as part of the designated record sets. Designated record sets are subject to the HIPAA record retention requirements. The Hospital is responsible for maintaining these records in accordance with the HIPAA record retention requirements.

F. Voluntary Restrictions:
Members of the Medical Staff and Practitioners who participate in the OHCA are prohibited from agreeing to any individual’s request for restrictions on the use or disclosure of individually identifiable health information that would be binding on other parties to the OHCA. The Hospital has sole authority to determine voluntary restrictions on the use or disclosure of individually identifiable health information and will notify OHCA participants of the voluntary restriction.

G. HIPAA Compliance Plan, Policies and Procedures:
The Hospital Compliance Plan and the policies, procedures, forms, and processes developed by Hospital for HIPAA compliance serve as the same policies, procedures, forms, and processes and Compliance Plan for the OHCA. Members of the Medical Staff and Practitioners in the OHCA shall refer individual requests to rights granted under HIPAA, including right to access, amendment, accounting for disclosures, voluntary restrictions, and complaints to the Hospital Privacy Official. The Hospital Privacy Official is responsible for the oversight and implementation of HIPAA compliance.

SECTION 4. CONFIDENTIALITY OF MEDICAL STAFF INFORMATION POLICY

A. Definitions
The definitions in the Medical Staff Bylaws shall apply to the terms in this policy.

B. Purpose
This policy applies to all records maintained by or on behalf of the Medical Staff, including the records and minutes of all Medical Staff committees, departments, the credentials and/or peer review files concerning individual members, including Medical Associates and Advanced Practice Professionals, and the records of all Medical Staff credentialing/peer review and performance improvement activities ("Medical Staff Records").

C. Participation in Reliance in Confidentiality
The Medical Staff and Hospital recognize that it is vital to maintain the confidentiality of Medical Staff Records. Medical Staff members, Medical Associates and Advanced Practice Professionals participate in credentialing/peer review and performance improvement activities in reliance upon the preservation of confidentiality. The members of the Medical Staff, Medical Associates and Advanced Practice Professionals understand and agree that the confidentiality of these activities, and of all Medical Staff Records, is to be preserved and that these communications, information, and records will be disclosed only in the furtherance of those credentialing/peer review and performance improvement activities, and only as specifically permitted under the conditions described in this policy. This requirement of confidentiality extends to the records and minutes of all Medical Staff committees and departments and to the records of all Medical Staff credentials/peer review files concerning individual members, including Advanced Practice Professionals and Medical Associates, and to the discussions and deliberations which take place within the confines or under the aegis of Medical Staff committees and departments. Accordingly, the records and proceedings of Medical Staff committees, departments and the participating members shall be afforded the fullest protection available under Title 39, Chapter 13 of the Idaho Code.

D. Preservation of Confidentiality
Members of the Medical Staff shall respect and preserve the confidentiality of all Medical Staff Records. Members pledge to invoke the protections of Title 39, Chapter 13 of the Idaho Code as applicable in legal proceedings in which this Medical Staff Records are sought, in order to preserve the confidentiality of this information.

E. Corrective Action for Breach of Confidentiality
The quality of patient care and the future of the Hospital and the Medical Staff as organizations depend upon effective credentialing, peer review and performance improvement. Effective credentialing, peer review and performance improvement activities depend upon the frank and candid exchange of information which is only possible if the confidentiality of Medical Staff discussions and proceedings is preserved. Consequently, any breach of the confidentiality of Medical Staff Records represents a failure to meet the professional and ethical standards of the Medical Staff and constitutes a disruption to the operations of the Hospital. If it is determined that a breach of that type has occurred, the Medical Staff may undertake appropriate corrective action.

F. Location and Security Precautions
All Medical Staff Records shall be maintained in the Medical Staff Office, under the custody of the Medical Staff Coordinator. The Medical Staff Office will be locked, except during those times that the Medical Staff Coordinator, or an authorized representative, is present and able to monitor access in accordance with this policy. Medical Staff Records will only be released from that office in accordance with this policy.

G. Access by Persons Within the Hospital and Medical Staff
1. Means of Access:
   All requests for Medical Staff Records by persons within the Hospital and Medical Staff shall be presented to the Medical Staff Coordinator. Those requests which require notice to or approval by other officials shall be forwarded to those persons by the Medical Staff Coordinator. A person permitted access under this policy shall be given a reasonable opportunity to inspect the records in question and to make notes, but will not be allowed to remove them from the Medical Staff Office or to make copies of them. Removal or copying shall only be allowed upon the express permission of the President of the Medical Staff, or his designated representative, and the Chief Executive Officer, or his designated representative, or as otherwise expressly permitted hereunder.

2. Access by Persons Performing Official Hospital or Medical Staff Function:
   Medical Staff officers, the President of the Medical Staff, Medical Staff committee or department members, members of the Board, the Medical Staff Coordinator, the Chief Executive Officer, or authorized representative, and any other persons assisting in credentialing/peer review or performance improvement activities may have access to Medical Staff Records, other than their own, to the extent necessary to perform their official functions. More particularly:
   a. Medical Staff Officers: Medical Staff officers shall have access to all Medical Staff Records to the extent necessary to perform their official functions.
   b. Medical Staff Committee/Department Members: Medical Staff committee/department members shall have access to the records of committees/departments on which they serve and to the credentials/peer review and performance improvement files of members whose qualifications or performance the committee/department is reviewing as part of its official functions.
   c. Chief Executive Officer/Designated Representative: The Board and the Chief Executive Officer, as its designated representative, shall have access to the Medical Staff Records to the extent necessary to perform their official functions.
   d. Medical Staff: The Medical Staff shall have access to the Medical Staff Records to the extent necessary to perform official functions.

3. General Access by Members to Medical Staff Records:
   a. Credentials/Peer Review Files: A member will have access to the credentials/peer review files of other members only as set out above. A member may have copies of any documents in the credentials/peer review file, which he submitted (that is, his initial appointment application, application for reappointment, request for privileges or correspondence from himself) or which were addressed to him or of which copies were earlier provided to him. A member will be allowed access to further information in his credentials/peer review file only if, following a written request by the member, the Executive Committee and either the Board or its designated representative grant written permission for good cause.
   b. Medical Staff Committee/Department Files: Except as provided above, a member shall be allowed access to Medical Staff committee/department files (including committee/department minutes) only if, following a written request by the member,
the Executive Committee and either the Board or its designated representative grant written permission for good cause.

c. Good Cause: Factors to be considered in determining whether good cause exists include the reasons for which access is requested, whether the member might further release the information, whether the information could be obtained in a less intrusive manner, whether the information was obtained in specific reliance upon continued confidentiality, whether the member will suffer specific serious adverse consequences unless the information is released, and whether a harmful precedent might be established by the release.

H. Access by Persons or Organizations Outside the Hospital or Medical Staff

1. Requests by Other Health Care Facilities or Managed Care Providers:

   a. Information contained in a credentials/peer review file, or other information, which is subject to this policy, may be released in response to a request from another health care facility or its Medical Staff. That request must include information that the member is a member of the requesting facility's Medical Staff, exercises privileges at the requesting facility, is an applicant for Medical Staff membership or privileges at that facility, seeks to be a managed care participant, or is an applicant for Medical Staff membership or privileges at that facility, and must include a release for such records signed by the concerned member. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.

   b. If a member has been the subject of corrective action at this Hospital, special care must be taken. All responses to inquiries regarding that member shall be reviewed and approved by the President of the Medical Staff, or his designee, and the Chief Executive Officer, or his designee.

2. Request by Hospital Surveyors:

   Hospital surveyors (from the TJC or any other Hospital surveyors) shall be entitled to inspect Medical Staff Records on the Hospital premises in the presence of Hospital or Medical Staff personnel provided that:

   a. no originals or copies may be removed from the premises;

   b. access is only with the concurrence of the President of the Medical Staff, or designee, and Chief Executive Officer, or designee; and the surveyor demonstrates the following:
      • specific statutory, regulatory or other authority to review the requested materials;
      • that the materials sought are directly relevant to the matter being investigated;
      • that the materials sought are the most direct and least intrusive means to carry out the survey or a pending investigation, bearing in mind that credentials/peer review files regarding individual members are confidential, so long as inspection does not invalidate the privileges contained in Title 39, Chapter 13 of the Idaho Code;
      • sufficient specificity to allow for the production of individual documents without undue burden to the Hospital or Medical Staff; and
• in the case of requests for documents with member identifiers not eliminated, the need for such identifiers.

Additionally, the surveyor should be asked to sign the Confidentiality and Notification Statement attached to this Policy as Appendix A and should be given a photocopy of the signed statement. If he declines to sign, it should be noted at the bottom of the statement that the surveyor, identified by name, has declined to sign but has been provided with a copy of the statement. The annotated statement should then be signed and dated by a Hospital or Medical Staff representative and a photocopy of the signed and annotated statement should be given to the surveyor. The original shall be preserved as a Medical Staff Record.

This requirement shall be waived if a confidentiality agreement has been signed by the surveying organization with CHI.

3. Subpoenas:
   All subpoenas of Medical Staff Records shall be referred to the Chief Executive Officer and President of the Medical Staff who will consult with legal counsel regarding the appropriate response.

4. Other Requests:
   All other requests by persons or organizations outside the Hospital for information contained in the Medical Staff Records shall be forwarded to the President of the Medical Staff and the Chief Executive Officer. The release of any such information shall require the concurrence of the Executive Committee, or its designated representative, and the Chief Executive Officer, or designee.

I. Credential File Changes

1. Correction or Deletion:
   A Medical Staff member shall have an opportunity to request correction or deletion of and to make additions to information in his credentials file, subject to the following provisions:

   a. When a member has reviewed his file, as provided under this policy, he may address to the President of the Medical Staff and Chief Executive Officer a written request for correction or deletion of information in his credentials file. Such request shall include a statement of the basis for the action requested.

   b. The President of the Medical Staff and Chief Executive Officer shall review such request within a reasonable time and shall recommend to the Executive Committee, after such review, whether or not to make the correction or deletion requested. The Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

   c. The member shall be notified promptly, in writing, of the decision of the Executive Committee.

   d. In any case, a member shall have the right to add to his own credentials file, upon
written request to the Executive Committee, a statement responding to any information contained in the file.

2. Notice to Members:
Notice to a Medical Staff member regarding the content of his credentials file shall be given when:

a. The required authorization of the President of the Medical Staff and Chief Executive Officer has been granted to disclose, as required by law, information contained in the member's credentials file; and
b. Adverse information is to be entered into his credentials file.

The notice of adverse information shall offer the member an opportunity to refute the adverse information before it is entered into the file.

This Confidentiality Policy is hereby adopted and placed into effect insofar as it is consistent with the Medical Staff Bylaws, until such time as it is amended in accordance with the terms of the Medical Staff Bylaws.

APPENDIX A
CONFIDENTIALITY AND NOTIFICATION STATEMENT

I have requested that I be allowed to inspect Medical Staff credentialing/peer review or performance improvement records. In recognition of Medical Staff confidentiality and the importance of such confidentiality to the performance of effective credentialing, performance improvement and peer review, and in recognition that the information in these records was both generated and disclosed to me in reliance upon that confidentiality, I understand that I am expected:

1. To preserve the confidentiality of those records to the extent allowed by law, disclosing that information only as necessary for completion of the peer review process; and

2. To notify the Hospital prior to any further disclosure of that information outside the purpose stated below, whether pursuant to subpoena or otherwise, and to cooperate with any efforts of the Hospital to contest that disclosure.

3. Reason for review:

___________________________________________________________

___________________________________________________________

(Signature of Reviewer) (Witness)

(Date) (Date)
SECTION 5. SUPERVISION OF RESIDENTS

A. Policy
Saint Alphonsus Medical Center – Nampa, Inc. recognizes the value of medical education and acknowledges the benefits that residents provide to both patients and clinical staff. Saint Alphonsus Medical Center – Nampa, Inc. desires to assist residents in achieving their medical education objectives by making available the use of clinical and other facilities within the hospital.

B. Purpose
To establish a mechanism for authorizing clinical rotations by residents at Saint Alphonsus Medical Center – Nampa, Inc., under the supervision of an Active member, in good standing, of the medical staff of Saint Alphonsus Medical Center – Nampa, Inc. .

C. Responsibility
Personnel in the Medical Staff Office of Saint Alphonsus Medical Center – Nampa, Inc., employees of the hospital, and all members of the Active Medical Staff who serve as supervising physicians for residents.

D. Direct Supervision
Direct supervision requires the supervisor to be physically present and immediately accessible to designate or prescribe a course of action or to give procedural guidance, direction, and periodic evaluation.

E. General Guidelines
1. Patient Care: Residents shall be allowed to participate in patient care under the direct supervision of the Supervising Physician and with the consent of the patient. Patients have the right to accept or refuse examination by Residents.
2. Identification: Residents shall wear identification badges, which clearly identify them as such.
3. Supervising Physician: The identity of the Supervising Physician for each Resident, shall be readily available to hospital personnel and medical staff so individuals know whom to contact should a question arise.
4. Medical Records: It is the responsibility of the Supervising Physician to ensure that all records are completed in accordance with the policy and plans of the medical staff.
5. Privileges: Residents are not Licensed Independent Practitioners and do not have delineated privileges or authority to admit patients
6. Orientation: All Residents will complete an orientation at Saint Alphonsus Medical Center – Nampa, Inc. that includes information on the following: Code of Conduct, Safety, Confidentiality, Infection Control, Patient Rights and HIPAA.
7. Communication: The Medical Staff Office obtains information from the training program on all Residents, prior to the scheduled rotation at Saint Alphonsus Medical Center – Nampa, Inc.

Reports related to clinical rotations of all Residents are provided to the Credentials Committee, the Medical Executive Committee and the Board of Directors. The Medical Staff Office will provide house-wide notification of approved clinical rotations.
F. Residents
Residents are graduate medical students in temporary attendance at the hospital in a training capacity under the supervision of members of the Active Medical Staff.

1. Qualifications
Residents must be affiliated with a Residency Program accredited by the Accreditation Council of Graduate Medical Education (ACGME) as evidenced by an Affiliation Agreement between Saint Alphonsus Medical Center – Nampa, Inc. and the Residency Program.

2. Credentialing
Prior to participating in the clinical rotation at the hospital, Residents must complete an application form provided by the hospital and prescribed by the Board after consultation with the Credentials Committee and provide evidence of the following:

a. Affiliation with an approved Residency Program as noted above.
b. License with the Idaho State Board of Medicine
c. Current valid professional liability insurance coverage in amounts satisfactory to the hospital
d. Idaho State Board of Pharmacy Certificate (if applicable)
e. DEA Registration (if applicable)
f. Name of Supervising Physician(s)
g. Immunization Record: PPD within last year OR, if positive, a copy of negative chest x-ray results and evaluation of signs and symptoms. Results of MMR titers (measles, mumps and rubella).
h. OIG (Excluded Provider) Check
i. Criminal Background Check or evidence of Criminal Background Check by the residency/training program within the previous 24 months.

3. Scope of Activities
a. Residents shall be supervised by an Active member of the Medical Staff. The Supervising Physician is responsible for the patient care provided by the resident. The level of involvement in patient care by the Resident is determined by the Supervising Physician in accordance with the resident’s skill level and prior training and must fall within the scope of privileges of the Supervising Physician.
b. Significant Change In Patient Status: A Resident shall keep the Supervising Physician informed of any significant change in patient status.
c. Documentation in the Medical Record (in accordance with the Medical Staff Bylaws and Policy and Plans):
   • Residents may write admitting orders, daily orders, and daily progress notes that must be reviewed and co-signed by the Supervising Physician.
   • Residents may dictate admission history and physical notes, and discharge summaries. The supervising physician must co-sign all dictation, including admission H&P’s and discharge summaries
d. Procedures: Residents may participate in surgical or other invasive procedures under the direct supervision of the Supervising Physician.
e. ICU/CCU: All ICU/CCU patients are to be seen by the Supervising Physician upon
admission.

f. Deliveries: Residents may participate in deliveries under the direct supervision of the Supervising Physician.

4. Supervising Physician Responsibilities
   a. The identity of the Supervising Physician shall be readily available to hospital and medical staff so individuals know whom to contact should a question arise.
   b. The Supervising Physician Must:
      • Be a member of the Active Medical Staff at Saint Alphonsus Medical Center – Nampa, Inc..
      • Be available (or designate an alternate physician to be available) either in person or through other means, to provide consultation when requested and to intervene when necessary.
   c. Retain ultimate responsibility for the patient care rendered and ensure that all delegated activities are within the scope of the Resident training and experience.
   d. Direct and review the work, records, and practice of the Resident on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered.
   e. Report any concerns related to the quality of care, treatment and services, and educational needs of/by the Resident, to the Medical Executive Committee for review. The Medical Executive Committee may report such concerns to the appropriate training program.

5. Residents MAY NOT:
   a. Make rounds in lieu of the supervising physician
   b. Take call for the supervising physician

G. Saint Alphonsus Medical Center – Nampa, Inc. reserves the right to place conditions on the clinical rotation if it is deemed in the best interest of the hospital, the physicians, hospital staff, or for the safety and consideration of patients.

H. At the conclusion of the scheduled rotation, all previously approved scope of activities is terminated.
ANNUAL RESIDENT COMPETENCY
REPORT FOR ACADEMIC OR CALENDAR
YEAR ____________________________

During the academic year of 20__, Saint Alphonsus Medical CenterNampa hosted _______ Residents from the following Graduate Medical Education Programs:

| Number Family Practice Residents - Family Practice Residency-Boise, Idaho |
| Number Internal Medicine Residents - Internal Medicine Residency –Boise, Idaho |
| Number Surgical Residents |

City State

All of the Graduate Medical Education programs are accredited programs by the Accreditation Council on Graduate Medical Education (ACGME).

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>Supervising Physician:</th>
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<tbody>
<tr>
<td>Involvement In Any Sentinel Events?</td>
<td>Reported Incidents Involving Residents?</td>
</tr>
<tr>
<td>Resident Name:</td>
<td>Supervising Physician:</td>
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<td>Resident Name:</td>
<td>Supervising Physician:</td>
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Resident/resident competency report 122010.doc – Approved 01/04/201
SECTION 6. CONFLICT MANAGEMENT POLICY

Policy
To identify processes to resolve conflict between members of Saint Alphonsus Medical Center – Nampa's leadership groups or between leadership groups and the Medical Staff in relation to roles, accountabilities, policies/practices and procedures that have the potential to affect the safety of quality of care, treatment or services. Organizational structures are in place to provide a forum for professional dialogue to address concerns and avoid conflicts where possible. These include but are not limited to:

Hospital Leadership Meetings
Senior Leadership meetings
Director/Manager meetings
Individual meetings with Senior Leaders and Directors/Managers

Medical Staff Leadership Meetings
Medical Executive Committee

Medical Staff Meetings
Medical Staff department meetings or standing or ad hoc Medical Staff committees
Individual meetings between department chairs and department members
Medical Staff business meetings

Board Meetings
Saint Alphonsus Medical Center – Nampa Community Hospital Board ("Board").

Procedure
The Conflict Management Process:
Every reasonable attempt should be made to address issues of conflict at the local level; through the chain of command and existing policies and procedures. When this is not possible or successful, then the CEO/designee, President of the Medical Staff and Chair of the Board should collaborate as appropriate under the circumstances to take action to address the conflict to:

A. Determine the source of conflict and the parties involved;
B. Determine who should be included in the discussion. Representatives from the Senior Leadership Team, Medical Executive Committee and the Board should be included as appropriate;
C. Determine the appropriate setting to meet;
D. Determine the need to designate an internal "facilitator" to lead the discussion or the need to utilize a neutral third party from outside the organization;
E. Meet with the involved parties as early as possible to:
   1. Gather Information;
   2. Work with the parties to manage and resolve the conflict; and
   3. Identify immediate action if necessary to protect the safety and quality of care.
The Board Chair and/or the Board shall make the final decision as to the conflict.

Documentation
The findings/recommendations of the conflict/resolution process will be communicated to the Senior Leadership team, Medical Executive Committee, Board and the Medical Staff (if appropriate) in writing.
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CHAPTER I

CLINICAL DEPARTMENTS

SECTION 1. LIST OF DEPARTMENTS

The following clinical departments are established:

- Anesthesia;
- Cardiology;
- Emergency Medicine;
- Family Medicine;
- Medicine;
- Obstetrics/
  Gynecology;
- Pathology;
- Pediatrics;
- Radiology; and
- Surgery.

Additional departments as required from time to time may be established by the Medical Staff after considering recommendations from the Executive Committee.

SECTION 2. FUNCTIONS OF DEPARTMENTS

A. Each clinical department shall recommend to the Credentials Committee written criteria for the granting of clinical privileges within the department. Such criteria shall be consistent with and subject to the bylaws, policies and procedures and policy and plans of the Medical Staff and Hospital. Clinical privileges shall be based upon demonstrated current competence, training and experience.

B. Each department shall monitor and evaluate medical care questions and problems on a retrospective, concurrent and/or prospective basis in all major clinical activities of the department using data and information from hospital patient cases. This monitoring and evaluation must include at least:

1. The identification and collection of information about important aspects of care provided in the department;
2. The identification of the indicators used to monitor the quality and appropriateness of the important aspects of care; and
3. The evaluation of the quality and appropriateness of care

C. Each department shall recommend, subject to approval and adoption by the Executive Committee and Board, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or by the Hospital's Quality Management Department to monitor and evaluate patient care. When important problems in patient care and clinical performance or opportunities to improve care are identified, each
department shall document the actions taken and evaluate effectiveness of such actions.
D. In discharging these functions each department shall report to the Executive Committee after each meeting detailing its analysis of patient care, whenever further investigation and appropriate action involving any individual member of the department is indicated. Copies of these reports shall be filed with the Executive Committee and the Chief Executive Officer.
E. Each department shall establish and maintain such policies, protocols and procedures as are necessary. All such policies, protocols, and procedures shall be consistent with the objectives of the Board and consistent with these Bylaws and the Medical Staff Policy and Plans.

SECTION 3. DEPARTMENT CHAIRMAN

A. The chairman of each department shall be an appointee to the Active Staff who is qualified by training, experience and administrative ability for the position.
B. The chairman of each department shall be board certified or in the process of becoming board certified.
C. The chairman of each department shall be elected by members of the department in which he serves and shall serve a two-(2) year term. The name of the chairman so elected will be presented to the Board. The vice-chairman of each department shall be elected by the members of the department in which he serves. The name of the vice-chairman so elected will be presented to the Board. His tenure shall coincide with that of his chairman.
D. Removal of a chairman during his term of office may be initiated by a two-thirds (2/3) vote of all Active Staff appointees in the department.

SECTION 4. FUNCTIONS OF DEPARTMENT CHAIRMAN

Each chairman shall:

A. be responsible for the clinical and administrative activities within the department;
B. be a member of the Executive Committee;
C. be responsible for continuous assessment and improvement of the quality and appropriateness of patient care, treatment and services provided within the department;
D. monitor the professional performance of all individuals who have delineated clinical privileges in the department, and make recommendations thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
E. recommend criteria for clinical privileges in the department
F. recommend a sufficient number of qualified and competent individuals to provide clinical services;
G. be responsible for the integration of the department into the primary functions of the Hospital;
H. be responsible for the coordination and integration of interdepartmental and intradepartmental services;
I. be responsible for the development and implementation of policies and procedures that guide and support the provision of services;
J. be responsible for maintenance of quality control programs, as appropriate;
K. appoint ad hoc committees or working groups as necessary to carry out Performance
Improvement activities;
L. make a recommendation to the Credentials Committee concerning the appointment, reappointment and delineation of clinical privileges for all applicants seeking privileges in the department;
M. be responsible for the evaluation of all provisional appointees and recommend thereon to the Credentials Committee;
N. assist the Hospital, in accordance with the provisions of these Bylaws, with respect to the evaluation and granting of requests for temporary privileges;
O. be responsible within the department for the enforcement of these Bylaws and the policies and procedures and policy and plans of the Medical Staff;
P. be responsible for implementation within the department of actions taken by the Board and the Executive Committee;
Q. be responsible for the establishment, implementation and effectiveness of the orientation, teaching, education and research programs in the department;
R. report and recommend to Hospital Administration off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital.
S. recommend space and other resources needed by the department.
T. assist Hospital Administration in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Chief Executive Officer or the Board;
U. delegate review of applications for appointment, reappointment or clinical privileges, or questions that may arise to the vice-chairman or other member of the department, if he has a conflict of interest with the individual under review, or could be reasonably perceived to be biased;
V. delegate to the vice-chairman or other members of the department such other duties as he deems appropriate;
W. comply with the provisions of Chapter III in the Organizational Manual; and
X. determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
CHAPTER II - PART A: APPOINTMENT

SECTION 1. CHAIRMEN

Appointment of all committee chairmen will be made by the President in consultation with the Chief Executive Officer. Committee chairmen must comply with the provisions of Chapter III in the Organization Manual.

SECTION 2. MEMBERS

A. Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed annually by the President at the beginning of the Medical Staff Year, in consultation with the Chief Executive Officer, if requested. All appointed members may be removed and vacancies filled by the President at his discretion.

B. The Chief Executive Officer and the President or their respective designees shall be members, ex-officio without vote, of all committees, unless otherwise expressly provided.

C. Committee members must comply with Chapter III in the Organization Manual.

CHAPTER II - PART B: EXECUTIVE COMMITTEE

SECTION 1. COMPOSITION

A. The Executive Committee shall consist of the President, President-Elect, Secretary/Treasurer of the medical staff, a Hospitalist representative, and the chairman of each clinical department. The chairman of the Credentials Committee shall be a member, ex-officio, without vote.

B. The Executive Committee includes physicians and may include other licensed independent practitioners.

C. The President shall be chairman of the Executive Committee.

D. The Chief Executive Officer and Vice President of Medical Affairs, or their designees, attends meetings of the Executive Committee and may participate in its discussions, but without vote.

E. The Chairman of the Board, or his designee, may attend meetings of the Executive Committee and participate in its discussions, but without vote.

F. Members of the Executive Committee may not hold more than one (1) Medical Staff office simultaneously. (President, President-Elect, or Secretary Treasurer)

G. No fully licensed medical staff member actively practicing in the hospital is ineligible for membership on the Executive Committee solely because of his or her professional discipline or specialty.
SECTION 2. DUTIES

The duties of the Executive Committee shall be:

A. to 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;
B. to coordinate the activities and general policies of the various departments;
C. to implement policies of the Medical Staff which are not the responsibilities of the departments;
D. to provide liaison among the Medical Staff, the Chief Executive Officer and the Board;
E. to recommend action to the Chief Executive Officer on matters of medico-administrative and Hospital administrative nature;
F. to ensure that the Medical Staff is kept abreast of Conditions of Participation from the Centers of Medicare and Medicaid (CMS) and the Standards from The Joint Commission (TJC) and informed of the accreditation status of the Hospital;
G. to take steps to ensure the enforcement of Hospital and Medical Staff bylaws, policy and plans, policies and procedures in the best interest of patient care and of the Hospital on the part of all persons who hold appointment to the Medical Staff, and to make recommendations to the Board on actions described in Articles I, VII, IX, X and XI;
H. to refer situations involving questions of the clinical competence, patient care and treatment or case management of any persons who hold appointments to the Medical Staff to the Credentials Committee or to the Medical Staff Quality Committee, as appropriate.
I. to request evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant’s ability to perform the privileges requested;
J. to be responsible to the Board for the quality of professional services rendered to patients in the Hospital;
K. to determine minimum continuing education requirements for appointees to the Staff;
L. to make recommendations to the Board on the following matters:

- the Medical Staff membership;
- the Medical Staff structure;
- the mechanism used to review credentials and delineate individual clinical privileges, including criteria for clinical privileges and Focused Professional Practice Evaluation (FPPE);
- recommendations of individuals for Medical Staff appointment and reappointment;
- recommendations for delineated clinical privileges for each practitioner privileged through the medical staff process;
- the participation of the Medical Staff in performance improvement activities;
- the mechanism by which Medical Staff appointment may be terminated;
- the mechanism for fair hearing procedures;
- the appropriateness, clinical necessity, and timeliness of support services provided directly by the hospital or through referral contacts; and
- the Executive Committee’s review of and actions on reports of medical staff committees, departments, and other assigned activity groups.
M. to review, evaluate, and revise the Medical Staff peer review and Quality Improvement activities on a regular basis; and
N. to participate in quality assurance and improvement and peer review activities as set forth in the Idaho Code Sections 39-1392 through 39-1392f.

The chairman of the Executive Committee, his representative and such members of the committee as may be necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Executive Committee shall meet at least ten (10) times per year or as often as necessary to conduct business. The President will maintain reports of all meetings, which reports shall include the minutes of the various committees and departments of the Staff. Copies of all minutes and reports of the Executive Committee shall be transmitted to the Chief Executive Officer routinely, as prepared, and important actions of the Executive Committee shall be reported to the Staff as a part of the Executive Committee's report at each Staff meeting. Recommendations of the Executive Committee shall be transmitted to the Chief Executive Officer and through him to the Board as the committee deems appropriate.

SECTION 4. MODIFICATION OF DUTIES

The duties delegated to the Executive Committee pursuant to these Bylaws may be modified by amending these Bylaws in accordance with Article XIII.

CHAPTER II - PART C: HEALTHCARE ETHICS ADVISORY COMMITTEE

SECTION 1. COMPOSITION

The Healthcare Ethics Advisory Committee shall consist of physician representatives; the Director of Mission Integration; the Vice-President of Patient Care Services; representatives of Educational Resources, Spiritual Care Resources and Nursing Staff; a community representative; representatives of affiliates and subsidiaries; and other external and internal resources as needed. Appointments to the committee shall be made in accordance with the Healthcare Ethics Advisory Committee's policies and procedures.

SECTION 2. DUTIES

The duties of the Healthcare Ethics Advisory Committee shall be:

A. to advise the Medical Staff, Hospital Administration, Hospital staff, patients and families on matters of policy and decision-making that involve ethical considerations impacting patient care;
B. to develop guidelines and policy statements on ethical issues and questions as felt
appropriate by the committee or as requested by the Medical Staff, Hospital Administration or Hospital staff;

C. to assist and support the development of health care ethics educational programs according to the philosophy of health care of the Hospital and in cooperation with the Department of Educational Resources;

D. to explore current ethical issues and to anticipate ethical dilemmas and questions which may arise as a result of scientific progress in medicine and the lifesciences;

E. to provide a forum for the resolution of disagreements where ethical questions are concerned that arise among staff, patients and families concerning course of care while at the Hospital; and

F. to participate in quality assurance, performance improvement and peer review activities as set forth in the Idaho Code Sections 39-1392 through 39-1392f.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Healthcare Ethics Advisory Committee shall meet and make recommendations and reports as specified in the Healthcare Ethics Advisory Committee's policies and procedures.

CHAPTER II - PART D: BYLAWS COMMITTEE

SECTION 1. COMPOSITION

The Bylaws Committee shall include a representative from each department, a representative from Hospital Administration, and guests invited by the committee chairman.

SECTION 2. DUTIES

The duties of the Bylaws Committee shall be to see to it that these Bylaws and the policies and procedures and policy and plans of the Medical Staff adequately and accurately describe the structure of the Medical Staff, including, but not limited to: the mechanism used to review credentials and to delineate individual clinical privileges; the organization of the Medical Staff quality improvement activities including the procedures for conducting, evaluating, and revising such activities; the mechanism for terminating Medical Staff membership; and the fair hearing procedures. The Bylaws Committee shall see to it that these Bylaws and the policies and procedures and policy and plans of the Medical Staff are reviewed and updated as necessary.

SECTION 3. MEETINGS, REPORTS, AND RECOMMENDATIONS

The Bylaws Committee will meet as requested by its chairman or the President and shall make reports and recommendations to the Executive Committee as needed.
CHAPTER II - PART E: CREDENTIALS COMMITTEE

SECTION 1. COMPOSITION

The Credentials Committee will consist of the following:

A. At least four (4) but not greater than five (5) persons holding appointments to the active staff who, if practical, will not be serving simultaneously as either chair of a department or officer of the staff.
B. The past-Medical Staff President will be an ex-officio member of the Credentials Committee.
C. The Credentials Committee may also include, as ex-officio members, such representation from the Hospital Administration as is recommended by the Medical Executive Committee and approved by the Board.

APPOINTMENTS - The Medical Staff President will appoint one (1) member to the committee each year, for a term of five years.

CHAIR - The chair will be the member with the greatest number of years of service on the committee. The chair will serve for one (1) year.

VACANCIES - Upon notice of medical staff privilege resignation, the President of Medical Staff will appoint a successor to carry out role.

PRIMACY OF MEMBERSHIP - Service on this committee will be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties will not interfere.

SECTION 2. DUTIES

The duties of the Credentials Committee shall be:

A. to make recommendations to the Executive Committee regarding criteria for the granting of clinical privileges and proctoring;
B. with the exception of applications identified by the President, pursuant to Article VI, Part B, Section 1, or his designee, as having no apparent problems, to review the credentials of all applicants, to make such investigations of and interview applicants as may be necessary, and to make recommendations for appointment and reappointment and delineation of clinical privileges in compliance with these Bylaws;
C. with the exception of applications identified by the President, pursuant to Article VI, Part B, Section 1, or his designee, as having no apparent problems to make a report to the Executive Committee on each applicant for Medical Staff appointment, reappointment, and clinical privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges;
D. to review, as questions arise, all information available regarding the professional and clinical competence of persons currently appointed to the Medical Staff, their care and treatment of patients and case management, and as a result of such review, to make recommendations to
the Executive Committee for the granting, reduction or withdrawal of promotions, privileges, reappointments, and changes in the assignment of appointees to the various departments;

E. to review reports concerning the clinical privileges of Medical Staff appointees referred by any other Medical Staff committee, the President, the Chief Executive Officer or the Chairman of the Board and to make such recommendations as provided by these Bylaws; and

F. to participate in quality assurance, performance improvement and peer review activities as set forth in the Idaho Code Sections 39-1392 through 39-1392f.

The chairman of the Credentials Committee, the chairman's representative or such members of the committee as are deemed necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Credentials Committee may make.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Credentials Committee shall meet as often as necessary to conduct business and accomplish its duties and shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the Executive Committee, the Chief Executive Officer, and the Board.

CHAPTER II - PART F: PHARMACY AND THERAPEUTICS COMMITTEE

SECTION 1. COMPOSITION

The Pharmacy and Therapeutics Committee shall consist of at least three (3) Medical Staff appointees, one (1) hospital representative, and one (1) hospital pharmacist.

SECTION 2. DUTIES

The Pharmacy and Therapeutics Committee shall be responsible for:

A. the review of the appropriateness of the use of all classes and categories of drugs through the analysis of individual or aggregate patterns of drug practice;
B. the development of policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;
C. the review of all significant untoward drug reactions;
D. the maintenance of a formulary list;
E. the evaluation and, if appropriate, the approval of protocols concerned with the use of investigational or experimental drugs;
F. the use of antibiotics in the Hospital; and
G. participating in quality assurance and improvement and peer review activities as set forth in the Idaho Code Sections 39-1392 through 39-1392f.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Pharmacy and Therapeutics Committee shall meet quarterly or as often as necessary to conduct business, shall maintain a permanent record of its findings, proceedings and actions, and
shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer.

The committee shall report (with or without recommendation) to the Executive Committee, for its consideration and appropriate action, any situation involving questions of clinical competency, patient care and treatment or case management of any individual appointed to the Medical Staff.

The committee shall report (with or without recommendation) to the Executive Committee, for its consideration and appropriate action, any situation within the jurisdiction of the committee involving questions of professional ethics, infraction of Hospital or Medical Staff bylaws or policy and plans or unacceptable conduct on the part of any individual appointed to the Medical Staff.

CHAPTER II - PART G: INFECTION PREVENTION AND CONTROL COMMITTEE

SECTION 1. COMPOSITION

The Infection Prevention and Control Committee shall consist of the Medical Director of Pathology, the Infection Control Practitioner, and representatives from the following departments: Laboratory, Pharmacy, Nursing, Risk Management, Performance Improvement, Nutrition Services, Administration, Housekeeping, Facilities, Hospice and Nutrition Services.

SECTION 2. DUTIES

The Infection Prevention and Control Committee shall be responsible for:

A. the management and evaluation of the hospital-wide infection prevention and control program;
B. the formulation and maintenance of written policies and procedures related infection prevention and control;
C. the monitoring and surveillance of infection activity and methods of control; participating in quality assurance, performance improvement and peer review activities as set forth in the Idaho Code Sections 39-1392 through 39-1392f.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

A. The Infection Prevention and Control Committee shall meet quarterly or as often as necessary to conduct business, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer.
B. The committee shall report (with or without recommendation) to the Executive Committee, for its consideration and appropriate action, any situation involving questions of clinical competency, patient care and treatment or case management of any individual appointed to the Medical Staff.
C. The committee shall report (with or without recommendation) to the Executive Committee, for its consideration and appropriate action, any situation within the jurisdiction of the
committee involving questions of professional ethics, infraction of Hospital or Medical Staff bylaws or policy and plans or unacceptable conduct on the part of any individual appointed to the Medical Staff.

CHAPTER II - PART H: MEDICAL STAFF QUALITY COMMITTEE

The Medical Staff Quality Committee shall be an independent multi-specialty committee established by the Medical Executive Committee for the purpose of Focused Review of Practitioner Performance (peer review) and review of Ongoing Professional Practice Evaluations.

SECTION 1. COMPOSITION

The Medical Staff Quality Committee shall consist of the Vice-Chairs, or a designee, of Medical Staff Departments and a Physician Advisor. The Chairman shall be the Physician Advisor.

SECTION 2. DUTIES

Processes are outlined in the policy on Medical Staff Focused Review of Practitioner Performance and Ongoing Professional Practice Evaluation.

The Medical Staff Quality Committee shall:

A. Convene Focused Review of Practitioner Performance (Peer Review) as set forth in the Idaho Code Sections 39-1392-1392f. This review shall include:
   - Categorization of the care by established codes;
   - Consideration of system factors that may contribute to the outcome; and
   - Identification of opportunities for improvement and, when identified, an action plan.

B. Analyze adverse patterns and trends that are relevant to an individual’s performance, as identified in ongoing professional practice evaluations;

C. Examine utilization review and corporate compliance issues;

D. With input from Medical Staff Departments and through the Focused Review of Practitioner Performance and Ongoing Professional Practice Evaluation process, be involved in the measurement, assessment and improvement in the following:
   - Medical assessment and treatment of patients;
   - Coordination of care, treatment, and services with other practitioners and Hospital personnel, as relevant to the care, treatment, and services of an individual patient;
   - Education of patients and families;

E. Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process to determine whether to continue, limit or revoke any existing privilege(s);
F. Appropriate clinical practice patterns;
G. Significant departures from established patterns of clinical practice;
H. Use of medications;
I. Use of blood and blood components;
J. Operative and other procedures;
K. Sentinel Event data;
L. Patient safety data;
M. Infection Prevention and Control; and
N. Accurate, timely, and legible completion of the patient’s medical records

SECTION 3. OTHER FOCUSED REVIEW OF PRACTITIONER PERFORMANCE (PEER REVIEW) PROCESSES

The following chairs are responsible for conducting Focused Review of Practitioner Performance in their respective Departments and/or Committees:

- Emergency Medicine;
- Pathology;
- Radiology; and
- Infection Prevention and Control.

SECTION 4. MEETING FREQUENCY AND REPORTING REQUIREMENTS

The Medical Staff Quality Committee shall meet at least quarterly, or as often as necessary, to conduct business, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Executive Committee and to the Board Quality Committee.

CHAPTER II - PART I: WELL-BEING COMMITTEE

The Well-Being Committee is an ad hoc committee appointed by the medical staff.

SECTION 1. COMPOSITION

The Well-Being Committee shall be composed of no fewer than three (3) Active Medical Staff members, a majority of whom, including the Chairman, shall be physicians and one of whom should be a psychiatrist or a member of the Family Practice Department.

SECTION 2. DUTIES

A. The Well-Being Committee shall investigate, report, and make recommendations related to the health, well-being, or impairment of Medical Staff members as set forth in the Medical Staff Policy on Assisting the Impaired Licensed Independent Practitioner found in the Policy and Plans, Chapter XI, Section 2.
B. The Committee shall also consider general matters related to the health and well-being of
Medical Staff members and, with the approval of the Executive Committee, develop educational programs or related activities.


SECTION 3. REPORTS AND RECOMMENDATIONS

The Committee shall meet as often as necessary. It shall maintain only such records of its proceedings as it deems advisable and shall report on its activities as set forth in the Medical Staff Policy on Assisting the Impaired Medical Staff Member.

CHAPTER II - PART J: CRITICAL CARE COMMITTEE

SECTION 1. COMPOSITION

The Critical Care Committee shall include the Medical Director and Nursing Director of the Hospital's Critical Care Unit and at least two (2) other Members of the Staff who regularly use the Hospital's Critical Care Unit.

SECTION 2. DUTIES

The Critical Care Committee shall:

A. participate in quality assurance, performance improvement and peer review activities as set forth in the Idaho Code Sections 39-1392-39-1392f; and

B. develop, implement and maintain a plan for continuous delivery of quality care in the Critical Care Unit of the Hospital. This plan shall provide for development, implementation, and oversight of unit-specific policies and procedures, shall address the admission and discharge of patients to the Critical Care Unit, shall address communications systems as they relate to the Critical Care Unit, shall assure 24-hour in-hospital or on-call coverage of the Unit by the Director or his designee, and shall provide for ongoing performance improvement.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Critical Care Committee shall meet as often as necessary to conduct business, and shall report matters pertaining to performance improvement to the Executive Committee.

CHAPTER II - PART K: SURGICAL SERVICES COMMITTEE

SECTION 1. COMPOSITION

The Committee shall be composed of all Active Staff members of the Departments of Surgery, Anesthesia and OB/GYN, and physicians and staff representing other disciplines that are involved in the provision of surgical services.
SECTION 2. DUTIES

The duties of the Surgical Services Committee shall be:

A. To report quality assurance, performance improvement and/or peer review activities and refer case reviews, as needed, to Medical Staff Quality Committee, as set forth in the Idaho Code Sections 39-1392 through 39-1392f;
B. To review issues related to surgical/procedure system issues, both inpatient and outpatient and
C. Manage block time assignments and utilization.

Recommendations made by the Committee will be forwarded to the appropriate department(s) for action and implementation.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Surgical Services Committee shall meet as often as necessary to conduct business. It shall maintain a permanent record of its findings, proceedings, recommendations and actions.

CHAPTER II – PART L: SPECIAL COMMITTEES

Special committees shall be created and their members and chairmen shall be appointed by the President as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.
SECTION 1. PURPOSE AND PHILOSOPHY STATEMENT

The purpose of this Conflict of Interest policy is to help safeguard the integrity as well as the reputation of Saint Alphonsus Medical Center – Nampa and its Medical Staff, by fostering the proper and unbiased conduct of Medical Staff activities in the Hospital and all clinics and sites within the Hospital’s organizational structure. In addition, this policy exists to educate the Medical Staff about situations which may generate a conflict of interest and to provide a method of disclosure and managing of conflicts of interest.

SECTION 2. IDENTIFYING AND DEFINING CONFLICTS OF INTEREST

Medical Staff Members must conduct their affairs so as to avoid or minimize conflicts of interest or actions that an independent observer could reasonably perceive as conflicts of interest. When conflicts of interest do arise, Medical Staff members are expected to respond within the guidance provided in this 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.

A. The following are representative of conflict of interest situations. The situations presented are meant to provide an idea of common conflict of interest situations; the examples do not represent all circumstances which could be a conflict of interest:

1. Possessing a financial relationship and/or accepting financial benefits from a vendor or service provider of the Hospital, when the Medical Staff member is in a position to determine or influence the Hospital’s purchases from the vendor or service provider.
   a. A financial relationship is one where the Medical Staff member possesses or receives a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g. stocks, stock options or other ownership interest), food, travel or other personal gain.
   b. Financial benefits are usually associated with roles such as employment, management, independent contractor positions, consulting, speaking, membership on advisory committees, board membership and other activities from which remuneration is received or expected.
   c. Financial relationships and financial benefits which are less than $500 per year are
considered immaterial and are not required to be disclosed unless the Medical Staff member elects to do so.

2. Influence on purchases of equipment, instruments, materials or services for the Hospital from vendors in which the Medical Staff member, or an immediate family member, has a financial interest or receives financial benefit.

3. Influence upon the negotiation of contracts between the Hospital and private organizations with which the Medical Staff members, or immediate family member, has consulting or other significant relationships, or will receive favorable treatment as a result of such influence.

4. Improper use of Hospital resources for personal financial gain; and

5. Transmission to a private entity or individual for personal gain of Hospital-supported work, products, results, materials or other information that is not made generally available to the public.

B. Medical Staff members shall disclose all material financial interests in writing. A “material financial interest” exists when the Medical Staff member or his or her spouse/domestic partner/child/parent:

1. Has an employment, consulting or other financial arrangement with the Hospital, another Hospital or organization that provides healthcare excluding the physician’s individual or group practice.

2. Holds an ownership interest of at least 5% in another hospital or organization that provides healthcare excluding the physician’s individual or group practice.

3. Has any size ownership interest in an organization providing products or services to the Hospital or another hospital (including a financial interest in an entity which is engaged in an existing or proposed business relationship with the Hospital).

4. Receives more than 5% of his or her annual income from the conflicted financial interest.

SECTION 3. DISCLOSURE

A. Medical Staff members shall be afforded an opportunity, and have a duty, to disclose in writing, any actual or potential interest that could be reasonable perceived as a conflict of interest, as described above.

B. Medical Staff members will complete the Medical Staff Conflict of Interest Form at the time of initial application for medical staff membership, as part of the reappointment process and any time any material change in the Medical Staff member’s interests could reasonably be considered a conflict of interest, as described above.

C. Medical Staff members shall verbally disclose all interests that could potentially constitute or be perceived as a conflict of interest in the course of any Medical Staff meeting where such a disclosure may be relevant to the issues being discussed.

D. At time of candidacy or prior to appointment, Medical Staff members under consideration for a Medical Staff elected or appointed position shall have a duty to disclose in writing any actual or potential interest that could be reasonably perceived as a conflict of interest, as described above.

E. If a Medical Staff member is found to have a conflict of interest in relation to a matter that is
under consideration, the Medical Staff member shall abstain from voting and/or recuse himself or herself from discussions or actions pertaining to the matter under consideration; and all written disclosures or other information pertaining to a Medical Staff member or Medical Staff leader will be maintained in the Medical Staff Office.

F. Consistent with Joint Commission standard LD.04.02.01, this policy and procedure and the conflict of interest disclosed, and any information about the relationship between care, treatment, and services and financial incentives are available upon request to all patients, and those individuals who work for Saint Alphonsus Medical Center Nampa, including staff and licensed independent practitioners.

SECTION 4. PROCEDURE FOR DISCLOSURE AND MANAGEMENT OF CONFLICTS OF INTEREST

A. Disclosure
Whenever a Medical Staff member is in a situation where he or she may potentially be in a conflict of interest, that Member should disclose in writing the details of the situation. The disclosure should be submitted to the President of the Medical Staff and the Chief Executive Officer, or his or her designee. Following this disclosure, the President of the Medical Staff, Officers of the Medical Staff and the Chief Executive Officer, or his or her designee, will gather necessary information from the Medical Staff member and evaluate the situation in an effort to take appropriate action.

B. Conflict of Interest (COI) Management Plan
If the determination is made by the Medical Staff Officers and the Chief Executive Officer, or his or her designee, that a conflict of interest exists, a COI Plan will be created through dialogue and attempted agreement with the Medical Staff member. The COI Plan may include public disclosure of significant financial interest, monitoring of participation in decision-making by Medical Staff leadership as designated; disqualification of the Medical Staff members from participation in all or a portion of certain meetings and/or voting at said meetings; discontinuing the relationship that created the conflict and/or other reasonable measures deemed appropriate by the Officers of the Medical Staff in conjunction with the Chief Executive Officer, or his or her designee. The COI Plan will be kept on file in the Medical Staff Member’s Credentials file.

In the event that either the Medical Staff Officers and the Chief Executive Officer, or his or her designee, cannot agree on a COI Plan or the Medical Staff member and the Medical Staff Officers cannot agree on a COI Plan, the matter will be reviewed by the Medical Executive Committee for a recommended COI Plan, subject to Board approval.

If a Medical Staff Officer is the Medical Staff member with the conflict at issue, that Officer shall not participate in the evaluation or decision of how to manage the conflict of interest except to provide his or her input as would any other Medical Staff member.

C. Consequences of Non-Compliance with Policy
If it becomes apparent that a Medical Staff member is not in compliance with the provisions of this policy, whether through failure to disclose a conflict of interest, non-compliance with the COI Plan following disclosure or otherwise, any of the following remedial measures may
be taken as deemed appropriate by the President and President-Elect of the Medical Staff, depending on the nature of the non-compliance:

1. Verbal notification of the Medical Staff member affording him or her an opportunity to address the matter within a specified time frame.
2. Written notification warning, reprimanding and requiring that the Medical Staff member address the matter within a specified time frame.
3. Other remedy deemed appropriate under the circumstances, short of corrective action under the Bylaws; and/or
4. Referral for corrective action under the Bylaws.

Any failure of a Medical Staff member to cooperate in providing material information for consideration under this policy, failure to appear at meetings as requested, failure to abide by the recommended remedial measures under this policy shall be subject to referral for further action as outlined in the “Corrective Action Plan” of the Medical Staff Bylaws.
CONFLICT OF INTEREST DISCLOSURE FORM

Name: ______________________________________ Title: ___________________________

Organization/Department: ______________________________ Contact #: ______________________

The purpose of this form is for you to disclose any interest or affiliations that you or a family member(s) may have that, when considered in light of your position within or relationship to Saint Alphonsus Health System, hereafter referred to as SAINT ALPHONSUS, as a Medical Staff Member at any Saint Alphonsus facility, and may potentially create a conflict of interest (see examples on following page).

Please disclose your interests and affiliations with Saint Alphonsus Health System in one of the following boxes below:

☐ I do not have any conflicts of interest with SAINT ALPHONSUS. Neither do any family members.
☐ I do have a conflict/family member have a conflict (describe below)**
☐ I or a family member may have a conflict/not sure (describe below)**

Electronic Signature: ___________________________ Date: _______________________

Please describe the actual or potential conflict of interest below:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

*Potential and Actual Conflicts of Interest will be reviewed by the Department Chair/Service Line Leader at your respective hospital(s). The original form, with or without identified conflicts, should be filed in the Medical Staff Member’s Credentials File. A copy of all potential or actual conflicts should be sent to the System Integrity Officer.
POTENTIAL CONFLICTS OF INTEREST

• IN GENERAL: Medical staff members may not engage in any personal, business or professional activity which conflicts with the duties and responsibilities of their position within the organization.

• ENDORSEMENTS AND TESTIMONIALS: Suppliers, vendors, trade and professional organizations, and others may seek an endorsement or testimonial from medical staff members of SAINT ALPHONSUS. Medical staff members cannot agree to perform such endorsements or testimonials without prior written approval from the Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.

• FINANCIAL INTERESTS: Except for investments in large, publicly traded companies, medical staff members should disclose financial relationships to SAINT ALPHONSUS, medical staff leadership, and patients that could create a risk that professional judgment or actions regarding a primary interest (patient care, research, medical education) will be unduly influenced by personal, family, or friends’ gain.

• MEDICAL STAFF MEMBERS may not do business with, or on behalf of SAINT ALPHONSUS, or recommend that SAINT ALPHONSUS do business with a company in which the medical staff member or immediate family member has a financial interest or business relationship without first disclosing such relationship to the Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.

• If a medical staff’s family member works for a vendor, contractor, customer or competitor, and is in a position to influence the medical staff member’s decisions affecting SAINT ALPHONSUS with that vendor, contractor, customer or competitor, the medical staff member must promptly disclose the family member’s position to his/her Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.

• A conflict of interest may arise when a medical staff member serves as a board member for an outside organization that does business with or seeks to do business with SAINT ALPHONSUS. Public service is encouraged, but such positions must be disclosed to the medical staff member’s Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.

• Unless otherwise directed by SAINT ALPHONSUS, when speaking on public issues or as a member of an outside organization, medical staff members should not give or permit the appearance that they are speaking on behalf of SAINT ALPHONSUS.

• When serving as a member of an outside organization or in public office, medical staff members should consider abstaining from any decisions or discussions that could affect SAINT ALPHONSUS. The medical staff member should make the reason for abstaining clear to the outside organization or to the applicable public officials and advise his/her Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO about such matter.

• SELF-DEALING: Actions disloyal to the organization for personal gain are called “self-dealing” and are prohibited. Examples of self-dealing are stealing, or disclosing proprietary information so that you, a friend, an associate, or a family member may obtain a profit or other advantage.

• VENDORS and PHARMACEUTICAL INDUSTRY: Medical staff members are expected to maintain objective relationships with all current and potential health industry and pharmaceutical representatives. Medical staff members must not exert, or appear to exert, special influence on behalf of an industry representative or potential representative because of friendship or any other relationship. Medical staff members must disclose potential conflict of interest/relationships to SAINT ALPHONSUS, medical staff leadership, and as applicable to patients who are or may use these products.

• OUTSIDE EMPLOYMENT: Employment or medical staff membership with outside entities must not interfere or conflict with the performance of the medical staff member’s duties at SAINT ALPHONSUS.

• CONFIDENTIAL INFORMATION: The use of confidential, non-public information for personal advantage is prohibited.

Photocopies and/or facsimile copies of this Authorization will serve the same purpose as the originally executed document. Your electronic signature will be applied upon clicking the “Submit” button;
CHAPTER I - PART A: MEDICAL ASSOCIATES

SECTION 1. QUALIFICATIONS

A. Medical Associates are appropriately licensed or certified persons practicing a recognized health profession, which generally includes the exercise of independent professional judgment. All Medical Associate categories and privileges must be approved in advance by the Board. Medical Associates do not have admitting privileges and shall provide inpatient services only as consultants to an admitting physician. The current approved Medical Associate categories are:

- Clinical Psychologists
- Consulting Dermatologist

B. Every individual who applies to become a Medical Associate must meet the Qualifications and will be subject to the provisions of Article I, Part A, Section 2, a, c – i, Section 3 through Section 9 of these Bylaws.

C. Each applicant for Medical Associate status shall file an application on a form provided by the Hospital. Each applicant shall be evaluated by the appropriate Medical Staff department chairman and the Credentials Committee, which shall recommend to the Executive Committee of the Medical Staff, which shall recommend to the Board of Directors the privileges that the applicant shall be permitted to exercise in the Hospital. The final determination of the applicant’s privileges shall be made by the Board. The determination of the Board shall be final with no right of appeal except as set forth in Chapter IV Part C of this Medical Associates & APP's document.

D. Medical Associates may only engage in activities within the privileges specifically granted by the Board.

E. Medical Associates are not members of the Medical Staff and do not enjoy the prerogatives of Medical Staff membership.

CHAPTER I - PART B: ADVANCED PRACTICE PROFESSIONALS

SECTION 1. GENERAL

A. Advanced Practice Professionals (APPs) are appropriately licensed persons practicing a recognized health profession which generally includes the exercise of independent professional judgment under the collaboration or sponsorship of an employer or contracting physician. All APP categories and privileges must be approved, in advance, by the Credentials Committee, the Executive Committee of the Medical Staff and the Board of Directors.
B. The current approved Advanced Practice Professional categories are:

1. Sponsored Advanced Practice Professionals, which include:
   a. Certified Nurse Midwives
   b. Certified Nurse Anesthetists

2. Collaborating Advanced Practice Professionals, which include:
   a. Nurse Practitioners
   b. Physician Assistants
   c. Clinical Nurse Specialists

J. Any additional categories approved pursuant to section 1A above will be maintained in the Medical Staff Office.
K. APPs are not members of the Medical Staff and do not enjoy the prerogatives of Medical Staff membership.

SECTION 2. QUALIFICATIONS, APPLICATIONS OR PRIVILEGES

The qualifications, application or privileges of APPs will be governed by the Medical Staff Policy for Granting Privileges to Advanced Practice Professionals Ineligible for Medical Staff Membership.
CHAPTER II - PART A: ADVANCED PRACTICE PROFESSIONAL POLICY

SECTION 1. POLICY INFORMATION

Various physician specialties require support from Advanced Practice Professionals (APPs) who are not employed by the Hospital and may be directly employed by a physician, physician group, or contracted with a physician group. APPs who are employed by the Hospital are credentialed through human resources. APPs who are independent are processed through the Medical Staff Services Credentialing process which is equivalent to Human Resources process.

The following types of APPs may be granted permission to provide patient care services at Saint Alphonsus Medical - Nampa:

- Dental Assistants
- Non-Physician Surgical First Assistants
- Oral Surgery Assistants
- Scribes
- Surgical Technicians

APPs are not members of the Medical Staff and do not enjoy the prerogatives of Medical Staff membership. As such, they are not entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff.

SECTION 2. QUALIFICATIONS

Advanced Practice Professionals must be qualified by academic and clinical or other training to practice in a clinical or supportive role and may provide services only under the supervision of Medical Staff physicians with clinical privileges at the Hospital. In addition, APPs may provide services only when recommended by his or her employer or contracting physician, as permitted by this Hospital and in keeping with all applicable laws, regulations, rules, policy and plans, and procedures and protocols.

To be permitted to perform services, an applicant must:

A. Be a graduate of an accredited school or have completed a requisite course of study and training in his or her discipline;
B. Be legally qualified to practice in the given discipline in this state;
C. Have demonstrated clinical competence in his or her discipline;
D. Meet the specific qualifications and requirements established by the Hospital;
E. Meet any malpractice insurance conditions established by the Hospital; and
F. Not be excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.
SECTION 3. EXPECTATIONS

Advanced Practice Professionals are expected to:
A. Complete orientation;
B. Protect patients by adhering to Infection Prevention policies of the Hospital including annual influenza vaccination;
C. Comply with the Hospital’s Customer Services Standards and Standards of Conduct including interpersonal communication and professional conduct expectations;
D. Demonstrate compliance with all relevant Hospital and departmental policies and procedures, including those related to:
   1. Ethical and Religious Directives
   2. Drug and Alcohol Free Workplace;
   3. Safety and Environment of Care;
   4. Immunization (as required by their collaborating physician)
   5. Dress Code; and
   6. Name Badge.
E. Understand the means of accomplishing the essential functions of the job outlined on the job description
F. Maintain a criminal history free of material concerns

CHAPTER II - PART B: ADVANCED PRACTICE PROFESSIONAL PROCEDURE

SECTION 1. APPLICATION

Each applicant must complete an application form(s) supplied by the Hospital and deliver it to Medical Staff Services. Applications must be accompanied by:
A. Application fee;
B. Authorization for release of information;
C. Confidentiality and network access agreement;
D. Completed job description;
E. Proof of liability insurance;
F. Proof of Immunizations and/or health screening tests that are also required for their collaborating physician;
G. Collaborative Physician Agreement completed and signed by the APP and the collaborating physician;
H. Completed orientation acknowledgement.

SECTION 2. VERIFICATION

Medical Staff Services will seek to conduct primary source verification of information contained within the application (when applicable) and will seek to collect additional information as is deemed necessary to permit an adequate and complete evaluation of the individual’s request for permission to provide services. Verification will include:
A. Primary source verification of licensure, certification and/or registration (as applicable to the licensure), employment history and peer references;
B. Verification of identity by current driver’s license with photo, passport or other photo I.D;
C. Office of Inspector General screening;
D. Criminal Background Check.

Once the application is determined to be complete, Medical Staff Services will notify applicable Hospital director(s).

SECTION 3. EVALUATION AND REPORTING

Practice prerogatives are extended to APPs subject to annual competency review, including collaborating physician and department director competency evaluations. Failure to successfully complete an annual competency review is grounds for termination of practice prerogatives.

A report will be submitted to the Medical Executive Committee and Board annually concerning the identity, scope of practice, collaborating physician and competency of Medical Assistants who have been reviewed and approved according to this policy.
CHAPTER III

FPPE AND OPPE PROCESS

SECTION 1. PURPOSE/SCOPE

The purpose of this process is to monitor performance/competency of Advanced Practice Professionals in order to measure and continually improve performance and provide ongoing assessment in a measurable way.

SECTION 2. BACKGROUND

Physician Assistants, Certified Nurse Anesthetists, Clinical Nurse Specialists and Nurse Practitioners are Advanced Practice Professionals at Saint Alphonsus Medical Group and do not function independently by Hospital Policy. Physician collaboration is outlined in the collaborating physician agreement on file in the Medical Staff Office.

SECTION 3. GUIDELINES

A. Focused Professional Practice Evaluation (FPPE) during the provisional period will occur as follows:
   1. Five Cases will be reviewed each quarter and the results reported to the Department Chair;
   2. Department Chair will be notified of any adverse findings;
   3. At the end of the provisional period reports will be compiled and aggregate information will be reported to the Department Chair, Credentials Committee, Medical Executive Committee and the Board of Directors.

B. Ongoing Professional Practice Evaluation (OPPE)
   After the provisional period, ongoing evaluation will occur as follows:
   1. Cases are screened for peer review indicators If a finding is attributed to the Advanced Practice Professional, the case will be reviewed and tracked through the peer review system and reported at the time of reappointment;
   2. At the end of each reappointment period, the collaborating Physician or Department Director(s) will be asked to provide an evaluation.
   3. The Medical Staff Office will aggregate the information and report to the Department Chair who will make a recommendation for reappointment to the Credentials Committee, Medical Executive Committee and the Board of Directors.
SECTION 1. RESTRICTION, SUSPENSION, OR TERMINATION

A. Overview
The Executive Committee, President or Chief Executive Officer may, at any time, order the restriction, suspension, or termination of the privileges or status of any Medical Associate or Advanced Practice Professional (APP), with or without cause. If feasible, the person or body so doing shall consult the Department chairperson and any collaborating or sponsoring physician of the APP prior to taking action.

B. Grounds for Procedural Review Rights
Any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for procedural review rights:
1. Denial of Medical Associate or Advanced Practice Professional appointment and/or reappointment;
2. Revocation, suspension, restriction and/or involuntary reduction of Medical Associate or Advanced Practice Professional appointment and/or privileges; and
3. Precautionary suspension of Medical Associate or Advanced Practice Professional appointment and/or privileges;

C. Procedural Rights
Nothing contained in these Bylaws shall be interpreted to entitle a Medical Associate or an APP to the procedural rights set forth in any other article of these bylaws. Any Medical Associate or APP, however, shall have the right to challenge any action that would constitute grounds for procedural rights under Chapter IV, Section 1 B. by filing a written grievance with the Executive Committee within fifteen (15) days of such action. On receipt of such a grievance, the Executive Committee or its designee shall conduct an investigation that shall afford the practitioner an opportunity for an interview concerning the grievance. Any such interview shall not constitute a “hearing,” as that term is defined in the Fair Hearing Process and the procedural rules applicable to such hearings shall not apply. Before the interview, the practitioner shall be informed of the general nature and circumstances giving rise to the action, and the practitioner may present information relevant thereto at the interview. A record of the interview shall be made. The collaborating or sponsoring physician, if any, of the practitioner may participate in the interview. The Executive Committee, or its designee, shall make a decision based on the interview and all other information available to it.

SECTION 2. AUTOMATIC TERMINATION

The privileges of a Medical Associate or Advanced Practice Professional shall automatically
terminate, without right to procedural review, in the event:

A. The Medical Staff membership of all collaborating or sponsoring physician(s) of the APP is suspended, terminated, or restricted, whether voluntarily or involuntarily;
B. The APP’s collaborating or sponsoring physician(s) no longer agree(s) to act as a collaborator or sponsor for any reason, or the relationship between the APP and the collaborating or sponsoring physician(s), if any, is otherwise terminated, regardless of the reason;
C. A contractual, employment, or other relationship between the Hospital and one or more APPs in the affected category limits the number of APPs in that category who may practice at the Hospital;
D. The Medical Associate or APP license or certificate to practice expires, is revoked, suspended, or otherwise restricted; or
E. The Medical Associate or APP is excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid;

SECTION 3. REVIEW OF CATEGORY DECISION

The procedural rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for privileges at the Hospital. Questions regarding such decisions shall be submitted to the Board, which has the discretion to decline to review the request, or to review it using any procedure it deems appropriate.
CHAPTER V  

MEDICAL STAFF POLICY FOR GRANTING PRIVILEGES TO ADVANCED PRACTICE PROFESSIONALS INELIGIBLE FOR MEDICAL STAFF MEMBERSHIP

SECTION 1. DEFINITIONS

The definitions in the Medical Staff Bylaws shall apply to the terms in this policy.

SECTION 2. GENERAL INFORMATION

The Board permits certain types of Advanced Practice Professionals (APPs) who have not been appointed to the Medical Staff to provide patient care services. Such practitioners must be qualified by academic and clinical or other training to practice in a clinical or supportive role. APPs may provide services only under the supervision of Medical Staff physicians with clinical privileges at Saint Alphonsus Medical Group. In addition, APPs may provide services only as permitted by this Hospital and in keeping with all applicable laws, regulations, rules, policy and plans, and procedures and protocols including, but not limited to, applicable portions of the Medical Staff Bylaws.

APPs are not members of the Medical Staff and do not enjoy the prerogatives of Medical Staff membership. As such, they are not entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff.

The number of APPs under the collaboration of one physician or sponsorship of one physician or group, as well as the acts they may undertake, shall be consistent with applicable federal and state statutes and regulations, the policy and plans of the Medical Staff and the policies of the Hospital.

SECTION 3. ADVANCED PRACTICE PRACTITIONERS

The following types of APPs may be granted permission to provide patient care services at Saint Alphonsus Medical Center:

A. Sponsor: is a designated physician member of the Medical Staff who is responsible for entering into a collaborative relationship with the APP. Advanced Practice Professionals must be employed by a physician/group with permanent privileges on the Active Staff of Saint Alphonsus Medical Group who is/are willing and able to provide collaboration in patient management, provide consultations and accept referral of patients as delineated in the privileges approved by the Board. These practitioners that have a sponsored physician include:

1. Certified Nurse Midwives
2. Certified Nurse Anesthetists

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B. Collaboration: is the process whereby an APP and physician jointly manage the care of a patient, which has become complicated. The scope of collaboration may encompass the physician’s care of the patient, including a mutually agreed upon plan of care. When the physician must assume a dominant role in the care of the patient due to increased risk status, the APP may continue to participate in physical care of the patient. Effective communication between the APP and Physician is essential for ongoing collaborative management. Advanced Practice Professionals must be employed by, or contracted with, and collaborated by a member or members of the Medical Staff as delineated in the clinical privileges approved by the Board.

1. Nurse Practitioners
2. Physician Assistants
3. Clinical Nurse Specialists

C. Any additional categories approved pursuant to Chapter I, Part B, Section 1A of this Medical Associates and APP’s document. A list of all approved categories will be maintained in the Medical Staff Office.

SECTION 4. QUALIFICATIONS

To be permitted to perform services, an applicant must:

A. be a graduate of an accredited school;
B. be legally qualified to practice in the given discipline in this state;
C. have demonstrated clinical competence in his or her discipline;
D. meet the specific qualifications and requirements established by the Hospital;
E. meet any malpractice insurance conditions established by the Hospital;
F. where appropriate, hold current, valid federal and state narcotics certificates; and
G. not be excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

Practitioners who are employed by, or under contract with a Medical Staff member with clinical privileges at Saint Alphonsus Medical Center Group may be given permission to provide services only when recommended by his or her employer or contracting physician.

Collaborating or sponsoring physicians must be personally qualified and must be currently credentialed to provide the services and to perform the procedures being requested on behalf of the APPs.

SECTION 5. APPLICATIONS

A. Each Advanced Practice Professional applicant must complete application form(s) as indicated below:

1. Each applicant for the Advanced Practice Professional status shall submit a fully completed application and signed collaborating physician agreement form from each collaborating physician, sponsoring physician or group provided by the Hospital. Applications of Advanced Practice Professionals will be processed in the same manner as applications for Medical Staff Members as described by current medical staff bylaws, policies and procedures.
2. Each applicant shall be evaluated by the appropriate Medical Staff department chairperson
and the Credentials Committee, which shall recommend to the Executive Committee of the Medical Staff, which shall recommend to the Board of Directors the privileges which the applicant shall be permitted to exercise in the Hospital. The final determination of the applicant’s privileges shall be made by the Board. The determination of the Board shall be final with no right of appeal except as set forth in Chapter IV of this Medical Associate & APP's document.

3. Reappointment of Advanced Practice Professionals will be handled in the same manner as reappointments for Medical Staff Members as described by current medical staff bylaws, policies and procedures.

B. Applications must be accompanied by:

1. A written statement signed by the applicant’s employer supporting the request for permission to provide services and confirming that the applicant is currently employed by or under contract with the medical staff member or their employer;

2. A written agreement by the collaborating physician, sponsoring physician, or group, as appropriate, for the privileges requested, to:

   a. Assume responsibility for collaboration, sponsorship or monitoring of the applicant;
   
   b. Be available, or provide an alternate to be available, for consultation when requested, and to intervene when necessary;
   
   c. Assume responsibility for the care of any patient, when requested by the applicant, or required by policy, or in the interest of patient care; and
   
   d. Sponsored or Collaborating Physicians or their designee are required to co-sign all history and physicals and discharge summaries and should co-sign all orders and records as necessary.

SECTION 6. TERM AND REVIEW OF PRIVILEGES

A. Initial privileges shall be extended to Advanced Practice Professionals who have either a sponsoring or collaborating physician for a provisional period of twelve (12) months from the date they are granted or longer (for a period not to exceed one (1) additional year) if recommended by Credentials Committee. Continued privileges after the provisional period shall be for a period not to exceed 24 months and shall be conditioned on an evaluation of the applicable factors to be considered for continued privileges as determined by the medical staff and hospital.

B. Each Advanced Practice Professional’s application for continued privileges shall be evaluated by the appropriate Medical Staff department chairperson and the Credentials Committee, which shall recommend to the Executive Committee of the Medical Staff, which shall recommend to the Board of Directors the privileges, if any, the applicant shall continue to be permitted to exercise in the Hospital. This final determination shall be made by the Board and shall be final with no right of appeal except as set forth in Chapter IV of this Medical Associate & APP's document.

C. Each Advanced Practice Professional agrees to participate in quality assurance, performance improvement and peer review activities. The quality of care provided by each Advanced Practice Professional will be reviewed on an ongoing basis as set forth in the Advanced Practice Professional Performance Feedback Process Policy. Any concerns will be referred to an appropriate Medical Staff Department/Committee for review and follow-up.
SECTION 7. PROFESSIONAL ETHICS

All APPs providing services in the Hospital shall be governed by the principles of professional ethics established by both their profession and the law and shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops. No activity prohibited by said Directives shall be engaged in by any APPs providing services in the Hospital.

SECTION 8. ADHERENCE TO CORPORATE RESPONSIBILITY PROGRAM

All APPs shall abide by the Corporate Responsibility Program, including, without limitation, the Trinity Standards of Conduct and any related education and training requirements.