

POLICY AND PLANS

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CHAPTER I

MEDICAL RECORDS

SECTION 1. CONTENT OF THE MEDICAL RECORD

The medical record will contain those items required by state and federal law and applicable regulations. This record will include the following in legible English:

- Identification data, including the patient's name, address, date of birth, and the name of the patient's legally authorized representative, if any
- Any referrals and communications made to external or internal care providers and to community agencies
- The patient's response to care
- The reasons for admission or treatment
- Evidence of properly executed informed consent
- All diagnostic and therapeutic procedures and test results
- History and Physical as set forth in the Medical Staff Bylaws
- Clinical observations
- The diagnosis or diagnostic impression
- Every dose of medication administered and any adverse drug reaction
- Emergency care provided to the patient prior to arrival, if any
- All relevant diagnoses established during the course of care
- Evidence of known advance directives
- Every medication dispensed to an ambulatory patient or an inpatient on discharge
- Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia
- Progress notes recorded by the medical staff and other authorized individuals
- Admission date
- The goals of treatment and treatment plan
- Diagnostic, therapeutic and standing orders, if any
- All operative and other invasive procedures performed
- All reassessments and any revisions of the treatment plans
- Consultation reports
- Every medication ordered or prescribed for an inpatient
- Conclusions at termination of hospitalization and condition on discharge
- The record and findings of the patient's assessment
- Discharge instructions to the patient and family
- The legal status of the patients receiving mental health services
- Clinical resumes and discharge summaries, or a final progress note or transfer summary

The attending physician will be responsible for the timely, legible and complete preparation of his/her portion of the medical record for which he/she is responsible on each of his/her patients. The medical record will contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

SECTION 2.

A. History and Physical Requirements

- A. POLICY • An independent practitioner must perform the history & physical.
1. The privilege to perform and document a history & physical are fundamental rights of medical doctors and doctors of osteopathic medicine and therefore will be granted.
 2. A history & physical performed by an allied health practitioner, specifically granted a scope of practice to perform a history & physical must be countersigned as outlined in the Allied Health Plan.
 3. A history & physical performed by a resident or fellow is subject to the supervision guidelines outlined in the Medical Staff Policy & Plans.
 4. A history & physical performed by a podiatrist or dentist, specifically granted privileges to perform a complete history & physical requires the mandatory use of the Hospital's Pre-admission Testing Center.
 5. Podiatrists and dentists who have not been granted privileges to conduct a complete history & physical must complete the portion of the history & physical related to podiatry or dentistry, respectively. The remaining required components of the history & physical, as outlined in Section 3 of this policy, must be completed by an Active or Courtesy physician member of the SARMC Medical Staff.
 6. When the history & physical is not present before an operation or any potentially hazardous diagnostic procedure, the history and physical will be completed immediately prior to beginning the operation or procedure. The history and physical will be directly entered into the electronic medical record system and immediately available for other caregivers.
 7. It is recognized that the prenatal patient is a special situation in that, in and of itself, the prenatal course is a planned, systematic updating of the history & physical performed at the first visit and throughout the pregnancy. As such, the entire prenatal record can be utilized as the history & physical, provided it is updated to reflect the patient's condition upon admission.
- B. INPATIENTS • Patients admitted to Saint Alphonsus Regional Medical Center require a complete history and physical examination within twenty-four (24) hours of admission or prior to an operation or potentially hazardous procedure, whichever occurs first. A complete history and physical includes the chief complaint; details of the present illness; allergies; current medications; relevant past, social, and family histories; an inventory by body system; the results of diagnostic tests; a full physical examination; diagnosis/impression; and a plan of care.
- C. AMBULATORY PATIENTS •
1. Ambulatory patients receiving general, spinal or major regional anesthesia, moderate or deep sedation, require an appropriate history and physical examination to be present in the patient's medical record. When the history and physical is not present or available it will be immediately completed prior to beginning the operation or procedure. The history and physical will be directly entered into the electronic medical record system and immediately available for other caregivers. An appropriate history and physical includes, at a minimum, details of the present illness, allergies, current medications, past history, mental status, physical examination relevant to the present illness, cardiopulmonary examination, a preoperative diagnosis, and a treatment plan.
 2. Ambulatory patients, who will undergo a therapeutic or diagnostic procedure with local

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

- D. EMERGENCIES • In an emergency, when there is no time to record the history and physical examination, a note documenting the preoperative diagnosis is recorded prior to the procedure. The history and physical must then be documented within twenty-four (24) hours. Following the procedure, the attending practitioner will state in writing that delaying the procedure to document the history and physical would have been detrimental to the patient.
- E. THIRTY (30) DAY RULE • If a history and a physical examination have been performed within thirty (30) days before admission, a legible copy of this report may be used in the patient's medical record. If a history and physical has been completed more than 30 days prior to admission, a completely new history and physical must be performed and documented.
- F. UPDATE TO PATIENT'S CONDITION • If the history and physical was performed within thirty (30) days prior to admission and/or an operation or potentially hazardous diagnostic procedure then the patient will be reevaluated by a Practitioner with privileges to perform a history and physical examination. An entry is required to chart the changes or to indicate no change at the time of admission or immediately prior to an operation or potentially hazardous diagnostic procedure.
1. The update note must document an examination for any changes in the patient's condition since the time that the patient's H&P was performed that might be significant for the planned course of treatment.
 2. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed.
 3. In the situation where the patient is going to surgery within the first 24 hours of admission, the preanesthesia assessment may serve as the update to the patient's condition.
 4. In the situation where the patient is going to surgery after 24 hours of admission, the daily progress note may serve as the update to the patient's condition.
 5. If an Allied Health Provider (AHP), with approved scope of practice, provides the update to the history and physical, the update will be countersigned immediately prior to beginning the operation or procedure by the supervising or performing physician.
- G. DENTAL PATIENTS • For dental patients undergoing a procedure in the operating room, the preoperative assessment performed by the anesthesiologist will satisfy the update note requirement. The dentist must update that portion of the history and physical related to dentistry.
- H. HISTORY AND PHYSICAL CONDUCTED IN PHYSICIAN'S OFFICE •
1. Copies of histories and physicals performed by a member of the medical staff in their

office may be used in lieu of dictating a new one provided it meets the requirements for legibility, timeliness and content as described above.

2. A copy of a letter from a member of the medical staff to a referring physician is acceptable documentation of a history and physical provided it meets the requirements for legibility, timeliness and content as described above.

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

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

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

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

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

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

- diagnosis/impression
- complete nursing assessment
- plan of care
- indications for the procedure or observation

B . PROGRESS NOTES

Pertinent progress notes, including appropriate admission notes, will be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with plans, specific orders and results of pertinent tests.

Progress notes will be written at least daily. It is the responsibility of the attending physician to ensure that a progress note is documented for each of their hospitalized patients for each day that patient is hospitalized.

ACUTE AND SUB-ACUTE REHABILITATION INPATIENTS • Pertinent progress notes will be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical and rehabilitation related problems should be clearly identified in the progress notes and correlated with plans, specific orders and results of pertinent tests. Progress notes will be recorded at least three days a week. It is the responsibility of the attending rehabilitation physician to ensure that these progress notes are recorded for their patients.

SECTION 3. ANESTHESIA

For every patient who receives general, moderate, deep or conscious anesthesia; the following must be performed and documented by any practitioner who is qualified to administer anesthesia.

1. Pre-Anesthesia Evaluation: A pre-anesthesia evaluation is completed within 48 hours prior to surgery / procedure requiring anesthesia.
2. Intra-operative Anesthesia Record.
3. Post-Anesthesia Evaluation: A post anesthesia evaluation is completed no later than 48 hours after surgery/procedure requiring anesthesia services; but may not begin until the patient is sufficiently recovered from the anesthesia so as to participate in the evaluation. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge.

All anesthesia evaluations must be consistent with hospital policy.

SECTION 4. OPERATIVE REPORTS

A. IMMEDIATE POST-OPERATIVE/POST PROCEDURE PROGRESS NOTE

When the operative/procedure report is not placed in the medical record immediately, for example when there is a transcription delay, a progress note is entered in the medical record immediately following the surgery/procedure and before the patient is transferred to the next level of care. If the immediate progress note(s) is not written, the physician must accompany the patient to the next level of care and write the progress note at the next level of care.

REQUIRED COMPONENTS OF POST-OPERATIVE PROGRESS NOTE

1. preoperative diagnoses;
2. postoperative diagnoses;
3. name of procedure(s);
4. name of surgeon and assistant(s);

5. description of each procedure findings;
6. estimated blood loss;
7. specimens removed; and
8. physician signature

B. **OPERATIVE REPORT:** Operative reports will be dictated immediately following surgery for both outpatients and inpatients and the report promptly signed by the surgeon and made a part of the patient's medical record.

REQUIRED COMPONENTS OF OPERATIVE REPORT

1. preoperative diagnoses;
2. postoperative diagnoses;
3. name of procedure(s);
4. name of surgeon and assistant(s);
5. description of each procedure findings;
6. findings of the procedure(s)
7. estimated blood loss; if any
8. specimens removed; if any; and
9. physician signature

SECTION 5. TIME OUT – BEFORE INCISION /START OF PROCEDURE

The Time Out is defined as a period of interactive verbal communication involving all members of the physician led surgical/procedural team.

A time out will be conducted prior to the start of any surgical/invasive procedure. The Time Out should occur immediately prior to the incision or passing of the first instrument.

During time out, all team members agree to verbally verify:

- The correct patient identity
- Correct site
- Correct procedure to be performed. (See Universal Protocol in PPM)

SECTION 6. FINAL DIAGNOSIS

Final diagnoses will be recorded in full (without the use of symbols or abbreviations) and dated and signed by the responsible practitioner at the time of discharge of all patients.

This will be deemed equally as important as the actual discharge order.

SECTION 7. DISCHARGE SUMMARY/FINAL PROGRESS NOTE CLINICAL RESUME

A. **DISCHARGE SUMMARY** • A discharge summary will be dictated for all stays greater than or equal to forty-eight (48) hours and all deaths. The discharge summary includes the reason for hospitalization, significant findings, procedures performed and treatment rendered, the patient's condition at discharge, and any discharge instructions to the patient and family.

B. **DISCHARGE SUMMARY OR FINAL PROGRESS NOTE** • For patients that are hospitalized less than forty-eight (48) hours, and for newborns with uncomplicated deliveries, a discharge summary or

a final progress note will be written or dictated documenting the primary discharge diagnosis, the patient's condition at discharge, procedures performed, discharge instructions, and follow-up care required.

- C. FINAL ENTRY • For patients treated as out-patients, and who require a history and physical as required in this policy, a final entry will be written describing the procedures performed or treatment rendered, the patient's condition at discharge, discharge instructions, and follow-up care required. A written brief op note combined with a note from the nursing staff and/or Anesthesiologist will be deemed as fulfilling this requirement.
- D. AUTHENTICATION • All entries will be authenticated by the physician who originated the order.
- E. TIMELINESS • The records of discharged patients will be completed within thirty (30) days following discharge.

SECTION 8. RELEASE, OWNERSHIP AND AVAILABILITY OF ACCESS TO PATIENT RECORDS.

- A. CONSENT TO RELEASE • Written consent of the patient is required for release of medical records to persons not otherwise authorized to receive information. All releases of medical records will comply with all applicable law, rules and regulations.
- B. REMOVAL FROM HOSPITAL PROPERTY • All original records are the property of the hospital. Records may be removed from the hospital's property and safekeeping only in accordance with a court order, subpoena, statute, or hospital policy. In case of readmission of a patient, all previous records will be available for the use of the attending practitioner. This will apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee. Physician access to patient records for reasons other than continuing medical care, research, or quality improvement/peer review, requires a consent from the patient or patient's representative.
- C. ACCESS FOR RESEARCH • Access to all medical records of all patients will be afforded to members of the medical staff for bona fide study and research projects. The confidentiality of patient information must at all times be preserved. All projects will be approved by the Medical Executive Committee before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the medical staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
- D. PATIENT ACCESS • Access to, and copies of, the medical record will be made available to the patient or patient's guardian with the exception of psychiatric records. Due to the sensitive nature of psychiatric records and the potential harmful impact upon the patient or family member, access to or copies of such records will only be provided upon authorization of the patients legally authorized representative or the attending physician, or his/her designee in his/her absence, after considering the best interest of the patient. Such access and copies may be restricted to third parties, such as the patient's current physician or attorney, on the basis of the patient's best interest.

- E. ACCESS DENIAL • In the event any request for access to, or copy of, any psychiatric record is denied for any reason, the attending physician will place a written explanation for the denial in the patient's record. If the patient had been committed under court order, copies of the explanation will also be sent to the committing court and to the patient's representative.
- F. DRUG AND ALCOHOL TREATMENT RECORDS • Records of drug alcohol treatment will only be accessed or disclosed when the patient has specifically consented to the release of such records or to the extent necessary to meet a bona fide medical emergency or by appropriate court order.

**SECTION 9. POLICY FOR COMPLETION OF MEDICAL RECORDS (RED TAG
– BLUE TAG POLICY)**

- A. STANDARD DEFICIENCIES AND MESSAGE CENTER • Health Information Management (HIM) will review patient encounters for required patient health information. If provider documentation is not complete and/or authenticated as required, a deficiency will be assigned by HIM. All deficiencies assigned are available in the practitioner's Message Center for completion with the exception of paper deficiencies which do require the responsible practitioner to appear in HIM for completion.
- B. BLUE TAG • In the event a responsible practitioner fails to resolve any of the above deficiencies assigned to said practitioner within 15 days of the discharge date they will be placed on the Blue Tag list:
- C. ALLOCATION DATE • For the purposes hereof, the encounter "allocation date" defaults to the date of discharge.
- D. BLUE TAG NOTIFICATION • The responsible practitioner will be placed on the Blue Tag list and be given notice thereof, both verbally to his/her office, and by a written notice, facsimile, email and/or the U.S. mail.
 1. A Blue Tag letter (Notice of Incomplete Medical Records) will be sent to physicians with unresolved deficiencies > 14 days from allocation date.
 2. The Blue Tag Notice will include a required completion date that is 15 days from the date of the letter.
 3. Reports must be completed/dictated and authenticated before the end of the Blue Tag period for the deficiency to be resolved.
- E. RED TAG NOTIFICATION • If the deficiency(ies) are not corrected on or before 4:00 p.m. of the date identified on the Blue Tag Letter, said medical practitioner will be placed upon the Red Tag list and given notice, both verbally to his/her office and written, by certified mail, return receipt requested, of the following:
 1. That he/she has been placed on the Red Tag list for certain of the above- enumerated deficiencies;
 2. That he/she has thirty (30) days from the date of the notice to remedy said deficiency or deficiencies; and
 3. That his/her privileges to admit and treat patients, to request consultations with respect to them, or provide consultations, have been temporarily suspended, effective immediately, until he/she is removed from the Red Tag list, which will occur immediately after he/she has

completed his/her medical records and has notified the Manager of the Health Information Management Department or designee of such completion.

- F. RED TAG - TEMPORARY SUSPENSION • While on the Red Tag list, a physician's privileges to admit and treat patients have been temporarily suspended. The physician cannot schedule or perform procedures/surgery, consult, make rounds, provide call coverage, visit or treat patients for another physician or otherwise exercise any clinical privileges. While on the Red Tag list the practitioner may treat and request consultations on patients he/she has admitted to the hospital prior to the effective date of suspension. The appropriate individuals/departments will receive communication of the physicians who have been placed on the Red Tag list, and when physicians have been removed from the Red Tag list.
- G. RED TAG – HISTORY AND PHYSICAL • A complete history and physical examination will be completed for all inpatients within twenty-four (24) hours of admission or prior to procedure, whichever comes first. In the event the history and physical has not been completed, the responsible attending physician will be notified by telephone call to his/her office that suspension of admitting privileges will be effective immediately and said practitioner will be placed on the Red Tag list.
- H. RED TAG - OPERATIVE REPORT /PROCEDURE NOTE • In the event the operative/procedure report has not been completed by midnight of the day the procedure ended, the responsible physician will be notified the next day by telephone call to his/her office that suspension of admitting privileges will be effective immediately and that said practitioner will be placed on the Red Tag list.
- I. RED TAG – POST-OPERATIVE/ POST-PROCEDURE NOTE • In the event the immediate Post-Operative/Post-Procedure progress note has not been completed, the responsible physician will be notified the next day by telephone call to his/her office that suspension of admitting privileges will be effective immediately and that said practitioner will be placed on the Red Tag list.
- J. RELINQUISHMENT OF MEDICAL STAFF MEMBERSHIP • In the event said Red Tag deficiency or deficiencies are not remedied within the above thirty (30) day period, or the responsible practitioner violates the terms of his/her temporary suspension, the responsible practitioner will be deemed to have voluntarily relinquished his or her Medical Staff membership and clinical privileges as set forth in the Fair Hearing Plan
- K. EXTENSIONS • If mitigating circumstances exist, the existence of which will be determined by the chair of the department or his/her designee, in their sole discretion, the responsible practitioner has the right to request the chair of his/her department or his/her designee to extend the Blue Tag period. The granting of extensions will be within the sole discretion of the department chair, chair-elect or immediate past chair. All requests and extensions will be reduced to writing and placed in the physician's file.
- L. REPEATED OFFENSES • Any practitioner who appears on the Red Tag list more than four (4) times during a two-year appointment or reappointment period, will be placed on a provisional one year appointment. If the practitioner appears on the Red Tag list during that provisional one-year appointment, this will be considered a voluntary relinquishment of his/her staff membership and privileges. Nothing herein will be interpreted as extending the current staff appointment of the practitioner or affect the requirements of seeking reappointment as provided in the Medical Staff Bylaws.

NOTE: The required notice of the revocation as described above will be sent by certified mail, return receipt requested, to the responsible practitioner by the Saint Alphonsus Regional Medical Center Chief Executive Officer.

SECTION 10. ASSUMED NAMES

Admission of the patient under the name of another physician cannot be done, unless the second physician then assumes full responsibility for the patient and all medical records chart work pertaining to the patient.

SECTION 11. GENERAL MATTERS

- A. NOTATION ON ENTRIES • All clinical entries in the patient's medical records will be accurately dated, timed, and authenticated by written signature or identifiable initials, or electronic code known only to the practitioner. Illegible handwritten signatures must be accompanied by a legible printed name or dictation number. (Rev. 8/08)
- B. ABBREVIATIONS • Unapproved abbreviations and symbols, as defined by medical center policy, may not be used in orders, dictations, or other medical record entries.
- C. FILING OF MEDICAL RECORD • A medical record will not be permanently filed until it is completed by the responsible practitioner, or ordered filed incomplete by the department chair if the practitioner is no longer available.

SECTION 12. ORDERS

- I. **Policy Statement:** Orders must be clear, legible and complete. Orders that are illegible or incomplete will not be carried out until rewritten or clarified.
- II. **Definitions:**
 - A. A patient care order directs the performance or administration of a diagnostic test, treatment, procedure, prescribed medication, intervention or therapy. Such orders may be created by providers within the scope of their practice and license
- III. **Equipment:**
 - A. Electronic Health Record (EHR)
- IV. **Procedure:**
 - A. All orders will be dated, timed, and authenticated by written or electronic signature.
 - B. Illegible handwritten signatures must be accompanied by a legible printed name.
 - C. 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.
 - D. Order sets (eg paper sets, EHR Favorites or Power Plans) are authorized when dated, timed and authenticated by written or electronic signature.
 - E. Unapproved abbreviations and symbols, as defined by medical center policy, may not be used in orders, dictations, or other medical record entries.
 - F. Orders may not be sent via text, email, EHR tasking/instant messages, in progress notes or via Halo Spectrum.

1. 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).
2. The following Saint Alphonus colleagues are authorized to receive and input the verbal order into the medical record:
 - a. Registered Nurse (RN)
 - b. Licensed Practical Nurse (LPN)
 - c. Registered Therapist
 - d. Respiratory Care Practitioner
 - e. Pharmacist
 - f. Dietitian
 - g. Physician's Assistant (PA)
 - h. Nurse Practitioner (NP)
 - i. Medical Assistant (MA) in outpatient Clinics
 - j. Specialized Procedures Technologists
 - (1) Registered Radiology Technologist
 - k. Radiation Therapist
 - l. Radiation Dosimetrist
 - m. Radiation Physicist
3. 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:
 - a. For paper based medical records
 - (1) VORB (Verbal Order Read Back), followed by the signature of the person taking the order.
 - b. For electronic medical records
 - (1) Select appropriate communication order type eg 'verbal order' or 'phone order.'
 - (2) These orders are routed to the provider for electronic signature
4. As soon as possible, verbal orders must be authenticated through written or electronic signature by the provider who originated the order or another provider who is responsible for the care of the patient and who is authorized to write orders.
5. An authorized individual may decline to accept verbal orders which are not clearly expressed or are capable of misinterpretation and will so inform the provider. If an agreement is not met, Chain of Command communication will be instituted prior to initiation of order.

SECTION 13. INFORMED CONSENT

Policy Statement: It is the policy of Saint Alphonus Regional Medical Center, Saint Alphonus Medical Center 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 services 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 the 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 14. TRAINING IN THE ELECTRONIC MEDICAL RECORD

Medical staff recognizes the significant advance in using an electronic health record to be implemented October 1, 2010. The EHR tools will allow for greater patient safety and improved quality of care. Training will be necessary for the individual physician or LIP in order to fulfill regulatory documentation requirements (CMS and Joint Commission). All documents will be electronic, with remote signage capability. Effective usage of the electronic health record requires training. The informatics staff and trainers are available for one-on-one training, classroom training and online training is available. For reasons of patient safety and promotion of clinician competency and efficiency, medical staff leadership is setting the following training expectations:

New physicians and allied health providers (expected to begin work after October 1, 2010) 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 15. AUTOPSIES

The Medical staff will attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. The mechanism for documenting permission to perform an autopsy is currently located in the Policy and Plan Manual. The attending physician will be notified when the autopsy is being performed.

CHAPTER II

EMERGENCY SERVICES

SECTION 1. MEDICAL STAFF COVERAGE

A. GENERAL GUIDANCE • It is the responsibility of each medical staff department to determine which specialties and subspecialties need to provide on-call coverage for the Emergency Department (ED), establish the appropriate level of on-call coverage for these specialties and subspecialties (including any required back-up call coverage), and submit the on-call coverage plan to the Medical Executive Committee for approval on an annual basis. The level of on-call coverage shall take into consideration the number of specialists and subspecialists in the department and the frequency with which ED patients require the clinical services of a particular specialty or subspecialty as well as any Hospital accreditation or certification requirements for on-call coverage. If there is not a sufficient number of physicians in a particular specialty or subspecialty to reasonably provide on-call coverage for the ED on a full-time basis, then the Medical Executive Committee, working with the department and Hospital Administration, shall develop alternative methods of providing coverage for that clinical service. The members of each Department are required to participate in an Emergency Department call roster for twenty (20) cumulative years. Thereafter, continuing participation in call rosters is optional as long as there are a minimum of six (6) participants on each call roster, subject to the following exceptions:

1. when the number of qualified participants fails to meet the minimum number, the department may submit to the Medical Executive Committee a plan for approval that sets forth more restrictive guidelines; or
2. when the number of qualified participants exceeds the minimum number, the department may submit to the Medical Executive Committee a plan for approval that sets forth less restrictive guidelines.

Upon request of the member, the Medical Executive Committee may grant an exclusion to the mandatory call requirement on the basis that the member has reached sixty-five (65) years of age or older even if the member has not met the general requirement of twenty (20) cumulative years of call coverage service.

B. ON-CALL PHYSICIAN • Each department will maintain a roster of department members on call for each clinical service (“on-call physician”), and will provide these rosters to the Medical Access Center or assigned designation on a monthly basis. In the absence of a call roster, the Medical Executive Committee will establish one for the department. The on-call physician should be readily available to communicate telephonically with Saint Alphonsus and transferring facilities concerning the transfer of patients to Saint Alphonsus' ED. The on-call physician should also be available to evaluate patients at Saint Alphonsus:

1. who do not have a physician;
2. whose physician is not a member of the Medical Staff; or
3. who are in need of the on-call physician’s special expertise.

SECTION 2. ON-CALL COVERAGE AND CHANGES

The on-call physician will be readily available to communicate telephonically with Saint Alphonsus and transferring facilities concerning the transfer of patients to Saint Alphonsus' ED. The on-call physician will also be readily available for on site (Saint Alphonsus Curtis Road campus), prompt consultation with the ED physician regarding questions related to the on-call physician's area of expertise. If the on-call physician is not available for on site (Saint Alphonsus Curtis Road campus), prompt consultation, the on-call physician should arrange for another practitioner, credentialed by Saint Alphonsus, with appropriate privileges, in the specialty/same discipline, to provide on site (Saint Alphonsus Curtis Road campus), prompt consultation. If the on-call physician is unavoidably detained by other medical responsibilities, it is his/her responsibility to obtain coverage by another qualified physician unless the Medical Executive Committee has determined that the physician's specialty or subspecialty is not required to provide back-up call coverage. It is also the on-call physician's responsibility to notify the ED and the Office of Medical Affairs of any changes in the call roster. ^(rev 12/07)

SECTION 3. SCREENING OF EMERGENCY MEDICAL CONDITIONS AND FOLLOW-UP

- A. MEDICAL SCREENING EXAMINATIONS • All persons who present to Saint Alphonsus with a request for examination or treatment of a potential emergency medical condition will be provided an appropriate medical screening examination and stabilizing treatment as required by the Emergency Medical Treatment and Labor Act (EMTALA) and Saint Alphonsus' EMTALA Compliance Policy. The results of this medical screening examination, and a determination of whether the patient has an emergency medical condition, will be documented in the patient's medical record.
- B. QUALIFIED MEDICAL PERSONNEL • Subject to the following exceptions, the medical screening examination must be conducted by a physician:
1. Emergency Department: Nurse practitioners and physician assistants working in the Emergency Department are determined, pursuant to EMTALA, to be qualified to provide medical screening examination to persons who present to Saint Alphonsus' Emergency Department with a request for examination and treatment of a medical condition, in accordance with their respective Board approved scope of practice.
 2. Behavioral Health: Registered nurses who are Charge Nurses working in the Behavioral Health Unit are determined, pursuant to EMTALA, to be qualified to provide medical screening examinations to persons who present to Saint Alphonsus' Behavioral Health Unit with a request for examination and treatment of a psychiatric condition, in accordance with the registered nurses' scope of practice under their license.
 3. Family Maternity Center: Certified nurse midwives working in the Family Maternity Center are determined, pursuant to EMTALA, to be qualified to provide medical screening examinations to persons who present to Saint Alphonsus' Family Maternity Center with a request for examination and treatment of a maternity-related medical condition, in accordance with the certified nurse midwives' Board approved scope of practice,
- C. ON-CALL PHYSICIAN • If the ED physician determines that the services of the on-call physician are necessary either to evaluate the patient for an emergency medical condition or to assist in providing stabilizing treatment for a patient who had been determined to have an

emergency medical condition, the on-call physician must, if requested by the ED physician, come in to evaluate the patient in the emergency room.

D. FOLLOW-UP•

1. If the ED physician believes that a patient with an emergency medical condition can be treated in the ED sufficiently to allow for discharge from the ED, but the patient will require follow-up care on an outpatient basis that can only be provided by the on-call physician, then the ED physician should contact the on-call physician and offer to allow the on-call physician to provide treatment to the patient in the ED. No on-call physician will be required to provide follow-up care to a patient not personally seen by the on-call physician in the ED except by prior mutual agreement between the on-call physician and the ED physician.
2. If the Ed physician determines that a patient does not have an emergency medical condition or has an emergency medical condition that has stabilized in the ED but requires follow-up care after an emergency room visit, which cannot be provided by the ED physician, the patient should be provided with the names of appropriate practitioners by the ED physician for such follow-up care. These practitioners are not obligated to see the patient in follow-up.

SECTION 4. RESPONSE TIME FOR ON-CALL PHYSICIANS

The responsible physician will evaluate the patient as soon as possible when requested by the ED or admitting physician. The goal for response time is thirty (30) minutes or less in emergent conditions and sixty (60) minutes or less in urgent situations where life or limb are not threatened.

SECTION 5. PATIENT ADMISSIONS

A patient admitted to the Hospital will be seen by the admitting physician as urgently as required by the patient's needs. The admitting physician assumes responsibility for the overall management of a patient's care at the time the admitting physician accepts the patient for admission. The admitting physician must provide the admitting unit with admission orders. If requested by the admitting physician, the ED physician may document admitting orders to assist with patient transfer to the patient care unit. If a patient is admitted to a critical care unit, the patient must be personally evaluated by the admitting physician or intensive care consulting physician within four (4) hours of admission, or sooner, based on patient acuity. ^(rev 2/08)

SECTION 6. UN-STABILIZED EMERGENCY MEDICAL CONDITION

Patients with an un-stabilized emergency medical condition will be subject to inter-hospital transfer only if the medical benefits to the patient outweigh the risks, as certified by a physician, or if the patient requests the transfer in writing, all in compliance with EMTALA.

SECTION 7. APPRAISAL OF EMERGENCIES AND REFERRAL

Any off-campus location of the hospital that is not a dedicated emergency department must have and implement policies and procedures for the appraisal and initial treatment of emergencies and referral when appropriate.

SECTION 8. PATIENT REQUEST FOR SPECIFIC PHYSICIAN

The ED physician should respect the patient's request for consultation with a specific physician on the Medical Staff.

SECTION 9. CONTINUITY OF CARE

Patients being evaluated in the ED are regarded as outpatient admissions to the Hospital. Physicians on the Medical Staff are expected to provide continuous care for their patients admitted to the Hospital as provided in the Medical Staff Bylaws. Practitioners are expected to be available for consultation with the ED physician for any of their patients requiring emergency care. When a practitioner knows he/she will be unavailable, he/she should arrange for another appropriate practitioner to provide coverage for his/her patients.

SECTION 10. NOTIFICATION

The ED physician will notify the on-call physician as soon as possible once a critically ill (injured) patient is identified in the field for transfer. The ED physician will personally communicate with the on-call physician well in advance of the arrival of the critically ill (injured) patient to facilitate emergent evaluation by the on-call physician.

SECTION 11. FAILURE TO RESPOND

Failure by the on-call physician to respond to the ED will be referred to the on-call physician's department chair. If the department chair determines that the ED request was appropriate and the on-call physician refused to respond, precautionary suspension of clinical privileges may be initiated pursuant to the Medical Staff Bylaws. If a physician fails to appear in the ED after a request by the ED physician and transfer to another facility is required as a result of the on-call physician's failure to appear then the name of the on-call physician will be documented in the transfer paperwork pursuant to EMTALA.

CHAPTER III

PROFESSIONAL LIABILITY INSURANCE

SECTION 1. REQUIRED LIMITS OF LIABILITY INSURANCE

Each practitioner will maintain professional liability insurance in the minimum amount of \$1,000,000 (one million) per occurrence and \$3,000,000 (three million) aggregate. Medical students, residents, and fellows must be provided professional liability insurance by the sponsoring graduate medical program.

SECTION 2. REQUIRED INSURANCE CARRIER

The insurance must be issued from an insurance company licensed to do business in the State of Idaho with a rating of A or better in A.M. Best's Rating (Approved Insurer). Each practitioner must provide Saint Alphonsus with a current certificate of insurance in a form acceptable to Saint Alphonsus.

SECTION 3. NOTIFICATION OF CHANGES

If any practitioner changes insurance carriers for any reason, switches from "claims made" to "occurrence" coverage, or has coverage terminated for any reason, the practitioner will notify the Office of Medical Affairs, at least thirty (30) days prior to the expiration of current coverage ("Expiration Date"); and obtain the requisite amount of minimum coverage with prior acts coverage that contains a retroactive date sufficient to cover any claims arising out of acts which occurred from the date the member was originally appointed to the Medical Staff through and including the expiration date.

SECTION 4. INSURANCE COVERAGE AFTER RESIGNATION

When any practitioner resigns, is removed from, or is not reappointed to the Medical Staff ("Withdrawal") for any reason and had claims made against insurance coverage will:

- A. PRIOR ACTS • Maintain "prior acts" coverage with a retroactive date sufficient to cover any claims arising out of acts that occurred from the date the practitioner was originally appointed to the Medical Staff through and including the date of withdrawal; or
- B. TAIL COVERAGE • Obtain an extended reporting endorsement ("tail coverage") from an approved insurer.

The practitioner will maintain the prior acts coverage or tail coverage for a minimum of five (5) years from the date of withdrawal or expiration date, as applicable. The practitioner will provide Saint Alphonsus Office of Medical Affairs with proof of coverage within thirty (30) days of the practitioner's withdrawal/expiration date.

CHAPTER IV

CONTINUING MEDICAL EDUCATION

SECTION 1. PURPOSE

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.

All Medical Staff members and others holding delineated clinical privileges who prescribe pharmaceuticals will be required to obtain two (2) hours of Opioid AMA PRA Category 1 accredited continue medical education prior to June 30, 2019.

SECTION 2. REPORTING

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. (Rev. 5/04)

CHAPTER V

MEDICAL STUDENTS, RESIDENTS AND FELLOWS

SECTION 1. MEDICAL STUDENTS

Medical students must be currently participating in an approved university program, as verified with the University, with an approved clinical affiliation.

- A. SCOPE OF ACTIVITIES • The Credentials Committee will specify, in writing, which of the following activities each applicant may undertake in the hospital:
1. Perform and discuss the History and Physical under the supervision of a physician;
 2. Create orders, including admit and discharge orders, in the electronic medical record, under the supervision of a physician with countersignature;
 3. write progress notes;
 4. dictate discharge summary countersigned by the attending physician;
 5. be responsible for the direct care of patients under the supervision of the attending physician on the medical staff; and/or
 6. assist in surgery.
- B. SUPERVISION • All activities of medical students must be under the direct supervision of members of the medical staff.

SECTION 2. RESIDENTS

A. DEFINITIONS •

Residents: Are graduate medical/dental students in temporary attendance for training in the hospital. Residents are not Licensed Independent Practitioners and as such do not have delineated clinical privileges and are not subject to the Basic Qualifications as outlined in Article I, Sec. III of the Medical Staff Bylaws.

- B. POLICY • Residents must be registered with the Idaho State Board of Medicine/Dentistry as set forth in Section 54-1807 of the Idaho Code.
- C. CONTENTS OF THE APPLICATION • Each application will contain the following:
1. a written request submitted to the Office of Medical Affairs on the approved form;
 2. current and verified photograph of applicant;
 3. all information and documentation requested on the Idaho Practitioner Credentials Verification Application form; and
 4. complete updated information requested on the original application or subsequent privilege request form, including but not limited to the following:
 - (a) appointments at other health care facilities, if applicable;
 - (b) voluntary or involuntary limitation, reduction, suspension or loss of clinical privileges at another hospital;
 - (c) involvement in liability claims;
 - (d) voluntary or involuntary cancellation of professional liability insurance, or license/Drug Enforcement Administration; and

(e) Medicare and Medicaid sanctions, including both current and pending investigations.

5. If resident is not coming directly from medical school and has practiced medicine in any capacity as an Independent Licensed Practitioner, two peer references, preferably from the same specialty (each reference will include a photo of the applicant to verify the identity of the applicant).

D. VERIFICATION PROCEDURES • At a minimum, the following will be verified for all Residents:

1. Primary source verification of licensure;
2. Acceptance by an AOA or ACGME accredited residency program;
3. Two peer references, preferably from the same specialty, if resident is not coming directly from medical school and has practiced medicine in any capacity as a Licensed Independent Practitioner.
4. Current professional liability certificate evidencing coverage within the required limits of Medical Staff Members;
5. Narcotics Registration Certificate (Federal and State) if applicable;
6. Criminal Background Check; and
7. If resident is not coming directly from medical school and has practiced medicine in any capacity as a Licensed Independent Practitioner, a National Practitioner Data Bank (NPBD) search and Office of Inspector (OIG) General search will be conducted.

E. SCOPE OF ACTIVITIES AND SUPERVISION •

1. Admitting Patients: Residents are not Licensed Independent Practitioners and as such do not have delineated clinical privileges or authority to admit patients. When a patient is admitted the following guidelines must be followed:
 - a. History and physical examination must be performed by the resident, documented within 24 hours and co-signed by the attending physician. The supervising/attending physician must be the admitting physician of record;
 - b. Attending physician must independently evaluate and document confirmation of the resident history and physical per the supervision table below.
2. Daily rounding: Residents must evaluate all patients on a daily basis and document such with a progress note and indicated orders. Orders and progress notes must be reviewed daily by the supervising physician/dentist who must see the patient and write a daily supervision progress note.
3. Consultations:
 - c. Consultations must be performed by the resident, documented within 24 hours and co-signed by the attending physician.
 - d. Attending physician must independently evaluate and document confirmation of the resident consultation note per the supervision table below.
4. Procedures: All procedures are to be supervised by a medical staff member with appropriate privileges.
5. Discharges: A discharge summary must be performed by the resident documented by the resident, and co-signed by the attending physician. The attending physician must also write a supervision note on the day of discharge.

GUIDELINES FOR SUPERVISION OF RESIDENTS • The definitions and the table below are provided as a minimum requirement for use by the attending physician when supervising a resident.

ACGME SUPERVISION DEFINITIONS • To ensure oversight of resident supervision and graded authority and responsibility, the residency program must use the following classification of supervision:

Direct Supervision - the supervising physician is physically present with the resident and patient.

Indirect Supervision -

(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight - the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be determined by the residency program director and faculty members.

	INTERNS (1ST YEAR RESIDENTS)	UPPER LEVEL RESIDENTS
HOSPITAL ADMISSIONS	All hospital admissions are seen at the time of admission by the resident and in a timely manner by the on call supervising physician/dentist.	Same as for first year residents except patients admitted to the non-intensive medical floor after 10 PM may, at the discretion of the on call supervising physician, be seen the following morning by the supervising physician.
CONSULTATIONS	Consultations are seen at the time of admission by the resident and in a timely manner by the on call supervising physician/dentist.	Same as for first year residents except consults after 10 PM may, at the discretion of the on call supervising physician, be seen the following morning by the supervising physician.
DAILY PROGRESS NOTES	All patients must have a daily resident progress note and supervision attending note.	Same as for first year residents.

DISCHARGES	All discharges are seen on the day of discharge by resident and the on call supervising physician/dentist.	Same as for first year residents.
EMERGENCY ROOM PATIENTS	All patients are seen by the resident and supervising physician/dentist ¹ . All patients to be admitted from the Emergency Department are seen initially by the resident, then by the on call supervising physician.	For patients admitted, same as for first year. Patients not admitted may, at the discretion of the on call supervising physician, be reviewed by phone.
INTENSIVE CARE UNIT/CARDIAC CARE UNIT	All admissions and transfers to the ICU/CCU are seen by the resident and on call supervising physician within four (4) hours, consistent with the Medical Staff Policy & Plans.	Same as for first year residents.
LABOR AND DELIVERY	All resident activities are supervised by a Medical Staff Member with appropriate privileges or senior resident certified in Electronic Fetal Monitoring. Deliveries are directly supervised by a Medical Staff Member with appropriate privileges.	All resident activities are supervised by a Medical Staff Member with appropriate privileges.
ORDERS	Orders written by the resident are reviewed by the on call supervising physician/dentist on a daily basis.	Same as for first year residents.
PROCEDURES	A qualified and privileged member of the medical staff supervises procedures performed by the resident.	Same as for first year residents.

¹ Dental residents may evaluate and treat the dental related condition, without supervision, if deemed appropriate by the emergency room physician. The Dental Residency faculty must provide follow-up care and evaluation the following day.

DURATION OF PARTICIPATION • Since residents are not members of the medical staff, and therefore do not have delineated clinical privileges, they will not be re-appointed at 24 months. Residents will be allowed to participate in clinical rotations at the hospital or related clinics for the duration of their residency program.

SECTION 3. FELLOWS

Fellows who have completed a residency and are Board-certified or Board-eligible are members in that specialty and are eligible for medical staff membership provided they meet minimum qualifications for medical staff membership. Supervision of fellowship procedures is provided by a medical staff member with appropriate privileges.

CHAPTER VI

LEAVE OF ABSENCE

SECTION 1. REQUESTING A LEAVE OF ABSENCE

A staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the chair of their department. The request must state the exact period of time of the leave and the reasons the staff member is seeking leave.

SECTION 2. DURATION OF LEAVE OF ABSENCE

A leave of absence will not normally exceed twelve months. Practitioners may be reappointed during a leave of absence contingent upon sufficient activity, during the current reappointment, to allow the department chair to make a judgment as it relates to current clinical competence. (Rev. 4/03)

SECTION 3. CONDITIONS FOR GRANTING LEAVE OF ABSENCE

Requests for leave must be accompanied with the following information:

- A. CONTINUITY OF CARE • The staff member must indicate a plan for the continuous care and supervision of his or her patients in the hospital;
- B. DUTIES • The staff member must provide documentation that they have been relieved of all staff, department, service, committee, or hospital functions from the department or committee chair;
- C. MEDICAL RECORDS • The staff member must complete all medical and other required records for all patients they have admitted or provided care to in the Hospital; and
- D. CAUSE • The staff member must provide good evidence to the Medical Executive Committee and the Board that good cause exists for granting such leave.

SECTION 4. MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee will review each request for a leave and all applicable information and will forward to the Chief Executive Officer for transmittal to the Board its report and recommendation that the leave be granted or denied. Thereafter the procedures outlined in the Medical Staff Credentials Manual, Chapter 1 will be followed.

SECTION 5. TERMINATION OF LEAVE OF ABSENCE

- A. FORMAL REQUEST FOR REINSTATEMENT • Except under those circumstances enumerated in Chapter VI, Section 5.B., a Practitioner who wishes to return from a voluntary leave of absence must, at least forty-five (45) days prior to the termination of his or her leave request to return from leave and have reinstatement of his or her privileges by submitting a written notice to the Chief Executive Officer which will be provided to the Credentials Committee. The Practitioner must submit a written summary of his or her relevant activities during the leave. The Credentials

Committee will make a recommendation to the Medical Executive Committee concerning the return from leave and reinstatement of the Practitioner's privileges. The Medical Executive Committee will review the matter and make a recommendation to the Board. (Rev. 4/03;6/06)

B. AUTOMATIC REINSTATEMENT • A Practitioner's privileges may be automatically reinstated upon a Practitioner's written request and without the need for the formal request for reinstatement process outlined in Chapter VI, Section 5.A. above, then a voluntary leave of absence was taken by the Practitioner under the following circumstances:

1. Maternity/Paternity;
2. humanitarian endeavors;
3. military service;
4. For the purpose of an investigation, once it is completed and following the Medical Executive Committee's approval of a recommendation that is not adverse as defined in the Medical Staff Bylaws, Policy and Plans; or
5. Other circumstances approved by the Department Chair, Credentials Committee, Medical Executive Committee and the Board and communicated to the Practitioner prior to the completion of the leave of absence. (Rev. 6/06)

Requests for a leave under this paragraph must contain the exact dates, fulfill all other requirements listed in this policy and must be specific regarding the purpose and circumstances of the request.

SECTION 6. FAILURE TO PROVIDE INFORMATION OR REQUEST REINSTATEMENT

Failure to request reinstatement or to provide a summary of activities will result in automatic termination of staff membership, privileges, and prerogatives without right of hearing or appellate review. Such automatic termination will not be deemed "adverse."

Termination under this policy does not preclude a subsequent request for medical staff privileges. Such request will be processed as an initial appointment as specified in the Credentials Manual.

CHAPTER VII

CREREDENTIALS FILE AND PROFESSIONAL PRACTICE FILE

SECTION 1. OVERVIEW

Two files will be designated and maintained to store documents and information concerning Members of the Medical Staff; the Credentials File and Professional Practice File, as set forth in this policy.

SECTION 2. CREDENTIALS FILE

- A. CONTENT • The Credentials File will contain information and documentation pertinent to the Medical Staff application, appointment, reappointment, and formal corrective action concerning each Member, including the following:
1. Application for initial appointment to the Medical Staff and related documentation, including:
 - a) written application;
 - b) letters of reference;
 - c) DEA registration;
 - d) Idaho license to practice medicine;
 - e) professional liability insurance information;
 - f) documentation of residence; and
 - g) any other documents submitted in support of and related to the initial application.
 2. Application for reappointment to the medical staff and documentation relating to reappointment, including the interval information form for each reappointment applicant;
 3. Requests for leave of absence;
 4. Application and related documents relating to clinical privileges;
 5. Application for temporary privileges;
 6. Requests for modification of appointment;
 7. Documents pertaining to the Office of Medical Affairs or Committee assignments;
 8. Written warnings, letters of reprimand, probationary items, requirement of review and/or consultation, documentation concerning denial, decrease, modification, restriction or suspension of clinical privileges, revocation of Medical Staff appointment, and written documentation of other formal and final corrective action(s) taken; and
 9. Documentation of denial of initial medical staff appointment, reappointment or requested advancement in a Medical Staff category.
- B. LOCATION OF AND ACCESS TO CREDENTIALS FILE • The Credentials File will be maintained in the Office of Medical Affairs and may be accessed by reviewing the electronic file online with an OMA (Office of Medical Affairs) colleague present. The following personnel are the only individuals authorized access:
1. The subject Medical Staff Member;
 2. President of the Medical Staff;
 3. President Elect of the Medical Staff;
 4. Physician Vice President or designee;

5. Medical Staff Member's department chair;
6. Medical Staff Member's clinical section chair;
7. Members of the Credentials Committee;
8. Saint Alphonsus Chief Executive Officer or designee;
9. Members of the Physician Professional Practice Committee;
10. Joint Commission on Accreditation of Healthcare Organizations and other entities required access by accreditation bodies or federal/state statutes or regulations;
11. Personnel assigned to the Office of Medical Affairs; and
12. All individuals and committees, including legal counsel, associated with a formal corrective action, hearing or appeal process, under the Bylaws.

- C. DUPLICATION AND DISTRIBUTION • The Hospital and its representatives may access and utilize information from the Credentials file needed for billing and claims submission in connection with a Practitioner's exercise of clinical privileges at the Hospital. (Added 10/06)

SECTION 3. PROFESSIONAL PRACTICE FILE

- A. CONTENT • The Professional Practice File will contain information concerning behaviors or incidents that, at the time of the respective behavior(s) or incident(s), do not rise to such a level as to require formal corrective action under the Corrective Action Plan but which, if repeated, could give rise to formal corrective action.

- B. LOCATION OF AND ACCESS TO PROFESSIONAL PRACTICE FILE • The Professional Practice File will be maintained in a removable file within the Medical Staff Member's Credentials File. In the event that the Credentials File is being accessed by an individual authorized access to the Credentials File but not listed below, the Professional Practice File will be removed.

1. The subject Medical Staff Member;
2. Officers of the Medical Staff;
3. Medical Staff Member's Department Chair;
4. Medical Staff Member's Clinical Section Chair;
5. Chair of the Credentials Committee;
6. Members of the Credentials Committee, at the discretion of the Credentials Committee Chair;
7. Members of the Physician Professional Practice Committee;
8. Physician Vice President or designee; (Added 4/03; Rev. 4/06)
9. Saint Alphonsus' Chief Executive Officer or designee;
10. Individuals and committees, including legal counsel, associated with a formal corrective action, hearing or appeal process, under the Bylaws;
11. Personnel assigned to the Office of Medical Affairs, at the direction of the President or President Elect of the Medical Staff; and
12. Saint Alphonsus Legal Counsel in consultation with any individuals and entities listed in this policy.

- C. LIMITATION ON PROFESSIONAL PRACTICE FILE ADDITIONS • No individual other than the Medical Staff Member's Department Chair, President, President Elect, Chair of the Physician Professional Practice Committee or Secretary Treasurer of the Medical Staff, and the subject

Medical Staff Member may place information or documents in the Medical Staff Member's Professional Practice File.

- D. STORAGE POLICY • Documents meeting the definition for entry into the Professional Practice File will be maintained indefinitely unless removed by the process outlined in paragraph E. of this policy.
- E. PERMANENT REMOVAL • In the event information is placed in the Professional Practice File, the Medical Staff Member will be allowed, at the Member's discretion, to submit rebuttal letters concerning incidents or behaviors that are subject of documents being added to the Professional Practice File. Rebuttal letters will be added to the Professional Practice File. While material added to the Professional Practice Files are not routinely removed, a Medical Staff Member may request that material be removed by petition to the Medical Executive Committee. The Medical Executive Committee may direct the material be removed by a 2/3 vote.

CHAPTER VIII

PERFORMANCE AND PEER REVIEW POLICY

SECTION 1. PURPOSE

This policy defines peer review and performance improvement and related terms and sets forth the manner in which peer review will be conducted. These processes serve the following purposes:

- A. PATIENT SAFETY AND QUALITY CARE • Assurance of patient safety and the quality of patient care by a review of medical staff performance, both individually and collectively;
- B. COMPETENCY DETERMINATION • Provision of a reasonable method for determining the competency of medical staff members; and
- C. PERFORMANCE IMPROVEMENT • Identification of individual, departmental and system opportunities for improvement and implementation of process improvements.

SECTION 2. DEFINITIONS

- A. PEER • For the purposes of this policy, a peer is defined as a practitioner, an MD or DO, privileged in this community, with appropriate subject matter expertise to evaluate the care provided in a particular case. In some cases, any practitioner experienced in caring for patients can provide the necessary level of subject matter expertise. In other cases, the appropriate level of subject matter expertise will require that those performing the review be privileged in the same specialty or department as the practitioner whose care is being evaluated.
- B. PEER REVIEW • Peer review is the evaluation of the quality of care provided, including identification of opportunities to improve care, carried out by Active and Active Ambulatory members of the Medical Staff with appropriate subject matter expertise. Peer review is conducted using multiple sources of information, including, but not limited to:
 - 1. the review of individual cases;
 - 2. the review of physician-specific data, compared to aggregate data, for compliance with clinical standards of care and general rules of the medical staff; and
 - 3. use of rates in comparison with established benchmarks or norms.
- C. DEPARTMENTAL PEER REVIEW PLANS • The departmental peer review plan describes the rule-based, rate-based, and case review indicators that will be used by the department to identify opportunities for improvement.
- D. RATE-BASED INDICATORS • Rate-based indicators are measurements (percentages or averages) of a particular aspect of performance that can be tracked over time. Circumstances requiring further analysis will be identified by defined triggers. These triggers may be based on protocol compliance levels, generally recognized professional guidelines for the practice of medicine, regulatory compliance standards, Trinity Health goals, national benchmarks, as available, and/or

rates placing a physician outside established parameters from the department mean for the indicator. All indicator definitions will include a trigger, with deviations greater than two standard deviations from the department mean as the default. Examples: Timely completion of medical records, selected complication rates, readmission rates, and mortality rates.

- E. CASE REVIEW INDICATORS • Case review indicators are events that require analysis by peers to determine the cause, effect, and severity of the outcome. Examples: unexpected death, significant post-procedure complication, sentinel event, referral (related to clinical competence), and self-referral.
- F. ONGOING PROFESSIONAL PRACTICE EVALUATION • Ongoing Professional Practice Evaluation (OPPE) is an ongoing process that allows the medical staff to monitor and conduct ongoing evaluations of each practitioner's professional performance. This process allows any potential problems with a practitioner's performance or trends that impact quality of care and patient safety to be identified and resolved in a timely manner. The OPPE also fosters an efficient, evidence-based privilege renewal process. The information resulting from the ongoing professional practice evaluation may be used to determine whether to continue, limit, or revoke any existing privilege(s).
- G. FOCUSED PROFESSIONAL PRACTICE EVALUATION • Focused Professional Practice Evaluation (FPPE) is a time-limited process that allows the medical staff to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at SARMC. FPPE will occur in all requests for new privileges and when there are concerns regarding the provision of safe, high quality care by a medical staff member (may be identified through Ongoing Professional Performance Evaluations).
- H. COMMUNITY STANDARD OF CARE • The determination of the community standard of care is a consensus-based process and necessitates the involvement of multiple peers. In rare instances, the medical staff also recognizes, particularly in controversial areas of medical care, that this determination may require the assistance of consultants from outside the SARMC Medical Staff and a review of pertinent medical literature.
- I. EXTERNAL PEER REVIEW • When an internal review cannot be unbiased, medical staff leaders may obtain external peer review from outside reviewers who are unbiased and likely of a similar training and experience. Other circumstances that may necessitate external peer review may include specialty review when there are limited or no medical staff members who can offer that review, and when requested by medical staff departments, other ad hoc medical staff panels, or standing committees of the medical staff.
- J. CONFIDENTIALITY • All Peer Review activities are confidential and privileged as provided in the Medical Staff Bylaws and Idaho Code Section 39-1392. It is the policy of Saint Alphonsus' Medical Staff to fulfill its responsibility to conduct peer review in an effective manner and, at the same time, respect an individual practitioner's expectations of confidentiality and fair treatment. Confidentiality allows for full cooperation and participation of the individual practitioners, and the resultant benefits.

SECTION 3. PERFORMANCE OF PEER REVIEW

A. MECHANISM • Peer review performs the following functions:

1. collects data on processes and outcomes, assesses performance in relation to national or community standards of care, analyzes how processes function, identifies opportunities for improvement, and reviews outcomes in relation to expectations;
2. evaluates individual practitioner performance;
3. provides data to department supervisory committees; and
4. provides individual performance data to Department Chairs for the purposes of reappointment, renewal of privileges, or revision of clinical privileges.

B. DATA COLLECTION • Data will be collected continuously from a variety of sources. These sources include, but are not limited to, computer and manual log entries; incident reporting systems; analysis of performance in relation to procedures, DRGs, diagnoses, pathology reports, autopsy reports; other internal and external databases; self-referral; and complaints. Physician specific and other peer review data will be collected under the authority and direction of the MEC and in collaboration with the medical staff departments, using resources in the Office of Medical Affairs and the Performance Improvement Department.

SECTION 4. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

OPPE is an ongoing process that allows the medical staff to monitor and conduct ongoing evaluations of each practitioner's professional performance. At a minimum, each department OPPE plan should include the following:

- A. OPPE will be performed for all practitioners on an ongoing basis, with data provided to the physician for review more frequently than every 12 months. Review of privileges will be evaluated at reappointment.
- B. Data reports and information that comprise OPPE include inpatient data for the individual physician and comparison with the aggregate of physicians with similar risk-adjusted cases. Each department will include measures to evaluate, at a minimum, the following:
 1. Patient care
 2. Practice-based learning and improvement
 3. Interpersonal and communication skills
 4. Professionalism
 5. System-based practice
 6. Medical/clinical knowledge
- C. The information gained by the review of the above information will be filed in provider's credentials file and incorporated into reappointment process.
- D. If behavior is identified as a possible issue, the Medical Staff Conduct Policy will be followed as a component of the OPPE.
- E. Relevant information obtained from the OPPE will be forwarded for inclusion into the performance improvement activities, at all times maintaining confidentiality.

SECTION 5. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

An intensified review is done by the Department Chair, when indicated by trended data or a trigger. Triggers are defined in Departmental OPPE plans and describe criteria by which a focused review will occur. These triggers will include:

1. Review at the time of new appointment to the Medical Staff to ensure clinical competency;
2. Fallout data identified at the time of re-credentialing and not considered by the Department Chair and Supervisory Committee to be explainable and acceptable;
3. A performance issue identified in the course of departmental peer review and considered by the Department Chair and Supervisory Committee to warrant further monitoring;
4. A performance issue identified by observation and considered by the Department Chair and Supervisory Committee to warrant further monitoring.

This process will be initiated as rapidly as possible, but not longer than 30 days from identification of the problem, after notification of the practitioner. The review of the practitioner may include:

- A. TRIGGERED REVIEW • A review of all cases identified by the specific indicator which triggered the review;
- B. RANDOM SAMPLING • Review of a random sample of cases for a 24 month period;
- C. PROSPECTIVE REVIEW • Review of all the practitioner's cases for the next 6 to 12 months; or
- D. OTHER REVIEWS • Any other review as defined by the Medical Executive Committee and/or the department chair.

At the conclusion of the intensified review, the findings and recommendations are reported to the department chair and the MEC. The MEC may, as appropriate note and if circumstances require, take steps including but not be limited to, collegial intervention, education, or referral of the matter to the appropriate body for carrying out the Corrective Action Plan.

SECTION 6. RESPONSIBILITIES AND ROLES

- A. PHYSICIANS are expected to:
 1. Participate in peer review activities as defined by and maintained by their department.
 2. Be present when requested to attend a committee or department meeting to discuss a case in which they were involved.
 3. Review their regular OPPE reports, and discuss any questions or concerns with their Department Chair.
 4. Work with the Department Chair and/or Departmental Supervisory Committee to resolve any performance issues identified through OPPE.
- B. DEPARTMENT CHAIRS, in consultation with his/her department and in collaboration with the Peer Review & Quality Committee, are required to:

1. Develop a specific peer review plan for his/her department every two years, for approval by the Peer Review and Quality Committee.
2. If determined to be necessary, establish and maintain a Supervisory Committee as described in Chapter III, "Supervisory Committees" in the Organization Manual of the Medical Staff Bylaws.
3. Review OPPE reports for any members of their department who fall outside of established parameters in any category of the evaluation.
4. Present a report on the fall-out data to the Departmental Supervisory Committee for determination of further action.
5. In collaboration with their Departmental Supervisory Committee, meet with physicians if further action is deemed appropriate, to agree on an action plan.
6. Communicate the result of these reviews and actions taken to the Peer Review Coordinator.

C. THE MEDICAL EXECUTIVE COMMITTEE will participate in the above processes by:

1. Monitor and participate in peer review as set for in the Medical Staff Bylaws and this Policy.
2. Determining appropriate steps in situations where an adequate action plan cannot be agreed upon by a physician, Department Chair, and Departmental Supervisory Committee.
3. Providing intervention when an issue compromising patient safety is brought forward for immediate action.

SECTION 7. SENTINEL EVENTS AND ROOT CAUSE ANALYSIS

The Medical Staff President or President Elect in conjunction with the Risk Manager will review all sentinel events and potential sentinel events. The physicians involved in the care of the patient, when appropriate, will be asked to participate in the root cause analysis within the 45- day timeline required by The Joint Commission.

The department chair(s) of the respective physician(s) will also participate in the root cause analysis, as appropriate.

The findings of the root cause analysis will be presented to the Medical Executive Committee. The involved practitioner(s) and department chair(s) will be present at the Medical Executive Committee during the review of the root cause analysis, as deemed appropriate by the medical staff leadership.

Physician participation in this process represents a fundamental responsibility and expectation for all members of the medical staff as noted in the Medical Staff Bylaws, Article I, Section 7. "Responsibilities of Each Member."

SECTION 8. ACCESS TO DATA

Access to Crimson reports is allowed for the following situations:

1. All medical staff may have access to their own Crimson data and are encouraged to do so.
2. Certain administrative staff with quality of care responsibilities, the CEO of SARMC and SAHS, CMO of SARMC and SAHS, Chief Quality Officer of SAHS and SARMC, staff of the Office of Medical Affairs, staff who assist in creating OPPE reports

3. President of the Medical Staff, President Elect of the Medical Staff, Credentials Committee and other Medical Executive Committee members (Dept Chairs may access the information on members of their departments and sections).
4. Individual physicians may grant access to Saint Alphonsus RMC management staff only by written permission of the physician.

SECTION 9. 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 involves 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 outline 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.

CHAPTER IX

STATEMENT OF RELEASE AND IMMUNITY FROM LIABILITY

SECTION 1. POLICY

To the fullest extent permitted by law, each applicant or member extends absolute immunity to, and release from liability, and agrees not to sue this Hospital or its employees, representative, agents, Medical Staff, or third parties for any actions, recommendations, reports, statements, communications, or disclosures involving the applicant or member, which are made, taken, given or received by this Hospital or its employees, representatives, agents, Medical Staff or third parties acting in good faith and without malice relating to, but not limited to the following:

- A. APPOINTMENT • Applications for appointment or clinical privileges, including temporary privileges;
- B. REAPPOINTMENT • Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
- C. ADVERSE ACTIONS • Proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;
- D. SUSPENSIONS •;
- E. HEARINGS AND APPELLATE REVIEW •;
- F. QUALITY IMPROVEMENT ACTIVITIES • Hospital and Medical Staff quality assessment/improvement requirements and programs;
- G. UTILIZATION REVIEW •;
- H. HOSPITAL ACTIVITIES • Any other Hospital, Medical Staff, department, service or committee activities;
- I. INQUIRIES • Matters or inquiries concerning professional qualifications, credentials, clinical competence, character, ability to perform privileges safely and competently, ethics, or behavior; and
- J. OTHER ACTIVITIES • Any other matter that might directly or indirectly have an effect on competence, on patient care, or on the orderly operation of this or any other health care facility.

The above will also be privileged to the fullest extent permitted by law and the privilege will extend to the Hospital and its authorized employees, representatives, agents, Medical Staff and to any third party.

SECTION 2. CONSULTATION AND INFORMATION EXCHANGE

Each member and applicant specifically authorizes the Hospital and its authorized employees, representatives, agents and Medical Staff to consult and exchange information, including otherwise privileged or confidential information, with third parties regarding the applicant's or member's professional qualifications, credentials, clinical competence, character, ability to perform privileges safely and competently, ethics, behavior, and any other qualities that might directly or indirectly bear on the applicant's or member's competence, patient care, or the orderly operation of this or any other hospital, health care organization, or health care facility. However, if a

member has a confidential file as defined in the Medical Staff Bylaws, Policy and Plans, prior to the release of information actually contained in a member's confidential file, Saint Alphonsus will require a written authorization from the member authorizing the release of information contained in the file.

SECTION 3. DEFINITIONS

- A. HOSPITAL AND ITS AUTHORIZED REPRESENTATIVES, EMPLOYEES, REPRESENTATIVES, AGENTS AND MEDICAL STAFF • means Saint Alphonsus Regional Medical Center and any of the following individuals who have any responsibility for obtaining, evaluating or reviewing a member or applicant's credentials, or acting upon such individual's application or conduct in the Hospital:
1. Members of the Board and their appointed representatives;
 2. the Chief Executive Officer or his or her designee;
 3. all Medical Staff officers;
 4. employees of the Office of Medical Affairs
 5. other Hospital employees;
 6. consultants to the Hospital; and
 7. the Hospital's attorney and his or her partners, associates, or designees.
- B. THIRD PARTIES • means all individuals from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives, including the following:
1. Medical Staff officers;
 2. employees of the Hospital's Office of Medical Affairs;
 3. all officers of the medical staffs and employees of the Office of Medical Affairs of other hospitals and health care facilities;
 4. other physicians or health care practitioners;
 5. nurses;
 6. government agencies;
 7. "health care organizations" as defined by Idaho's Peer Review Statute, Idaho Code Section 39-1392, *et seq.*; and
 8. other organizations, associations, partnerships, and corporations, whether hospitals, health care facilities or not.

SECTION 4. ACCEPTANCE OF POLICY

The applicant or member must accept this Statement of Release and Immunity from Liability as a condition of appointment and/or reappointment to the Medical Staff. By submitting an application for appointment, all applicants and members agree to the terms of this Statement of Release and Immunity from Liability, to the terms and conditions set forth in the Medical Staff Bylaws, Policy and Plans, Organization Manual and Allied Health Plan.

CHAPTER X

CONFLICT MANAGEMENT POLICY

SECTION 1. PURPOSE

To identify processes to resolve conflict between members of Saint Alphonus Regional Medical Center'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 Alphonus Regional Medical Center Community Hospital Board ("Community Hospital Board").

SECTION 2. 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 Community Hospital 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 Community Hospital 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 Community Hospital Board shall make the final decision as to the conflict.

SECTION 3. DOCUMENTATION:

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

CHAPTER XI

MISCELLANEOUS HOSPITAL POLICIES

SECTION I. HOSPITAL SUPPLIED PROCEDURAL ATTIRE

Affected Areas:

- A. Operating rooms, Anesthesia, Endoscopy, Electrophysiology Lab, Cardiac Catheterization lab, Sterile Processing, Interventional Radiology, Non Invasive Cardiac, Wound/Hyperbaric, NICU and FMC.

Process:

- A. Authorized personnel, from designated restricted and semi-restricted areas, will arrive in personal clothing and change into black hospital provided scrubs in the appropriate dressing area. Personnel should change into street clothes whenever they leave or depart the facility, and go outside. Before leaving the facility, personnel will change out of scrubs and deposit them in the designated container for laundering.
- B. Personal use of hospital owned scrubs or linens is not allowed.
- C. Removal of SARMC owned scrubs or linens from hospital premises is not allowed, except to provide the employee temporary clothing when a patient's blood or body fluids have soiled their personal clothing. In this circumstance, the employee will be provided temporary green SARMC scrubs. Contact Environmental services to have scrubs delivered. Green hospital owned scrubs are not to be working except on a temporary and emergency basis and returned within 5 working days.

Enforcement:

- A. Responsibility to educate providers as they come on staff during orientation process.
- B. Security officers, management and or hospital colleagues observing a scrub use policy infraction should attempt to obtain the name and department where the employee works and notify management immediately. It is management's responsibility to follow up and initiate appropriate corrective action. LIP infractions should be forwarded to the appropriate administrative leader for action and follow up.
- C. Violation of this policy may result in disciplinary action as described in By Laws Article XVI.

SECTION 2. TESTING AND VACCINATION

A Medical Staff Member or Allied Health Professional who fails to comply with the Trinity Health and Saint Alphonsus Regional Medical Center policy on required testing (e.g., Tb testing) or required vaccinations/immunizations (e.g., Covid-19) shall be automatically suspended until documentation of compliance is received. Failure to comply with this policy within sixty (60) calendar days of automatic **suspension** will be considered a voluntary relinquishment of appointment and clinical privileges (or for AHPs, scope of practice).

SECTION 3. PSYCHOLOGIST PRESCRIPTIVE AUTHORITY

- A. Psychologists seeking prescriptive authority must meet the following criteria:
 1. Graduated from an American Psychological Association (APA) program
 2. Supervising physician who is an Active member of the medical staff
 3. Qualified and approved by the licensing board for prescriptive authority

ARTICLE XIII

PROCESS FOR THE DEVELOPMENT OF PRIVILEGING CRITERIA

SECTION 1. PURPOSE

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

SECTION 2. POLICY

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

- A. PRIVILEGES THAT CROSS DEPARTMENT BOUNDARIES • When more than one department exercises the same privilege(s), thus making it necessary to define uniform criteria for the exercise of clinical privileges.
- B. NEW EQUIPMENT • When new equipment is used which requires specialized training for safe and competent use.
- C. NEW HOSPITAL PRIVILEGE • When practitioners request clinical privileges that are not within the scope of services at the Hospital; therefore, no criteria for the exercise of clinical privileges have been delineated.

SECTION 3. PROCEDURES FOR DEVELOPMENT OF PRIVILEGING CRITERIA

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

1. a list of the training programs attended and references;
2. the specialties that may be involved and/or the types of practitioners who exercise this/these privilege(s);
3. standards for granting such privilege(s) from each related department society/board/academies; and
4. other information requested.

C. DEPARTMENT CHAIR •

1. All of the required documentation will be submitted to the Department Chair for review and development at the next regularly scheduled department meeting. The Department Chair, or designee, will research issues related to the new privilege(s), utilizing the general guidelines in Article VIII, Section 3G of these Bylaws, and to develop criteria to determine those who are competent to exercise the Clinical Privilege(s) according to the guidelines.
2. The findings and recommendations will be forwarded to the Credentials Committee. The department will be given up to sixty (60) days to make a report/recommendation to the Credentials Committee after a request has been submitted by one of its members.

D. CREDENTIALS COMMITTEE •

1. The Department Chair will forward the request, and all supporting documentation, to the Credentials Committee, along with the information provided by the medical staff member.
2. The Credentials Committee will review the information and appoint an ad-hoc committee or refer the issue to an existing medical staff department or committee for the development of criteria for privilege(s) as appropriate.
3. When more than one department is involved in performing the requested privilege(s), the Credentials Committee will appoint an ad hoc committee with at least one representative from each department involved. Additional specialties may be appointed to the ad-hoc committee as appropriate, after considering conflict of interest issues, if any.
4. The ad-hoc committee or medical staff department will research issues related to the new privilege(s), utilizing the following general guidelines in Article VIII Section 3G and Article XII Section 1A of these Bylaws, and to develop criteria to determine those who are competent to exercise the Clinical Privilege(s) according to the guidelines. The ad-hoc committee or medical staff department will be given up to sixty (60) days to make a report/recommendation to the Credentials Committee.
5. The Credentials Committee will consider the report from the ad-hoc committee or medical staff department, and make a written recommendation (including the rationale for the recommendation) to the Medical Executive Committee.

E. MEDICAL EXECUTIVE COMMITTEE • The Medical Executive Committee will review the written recommendation of the Credentials Committee and make a final recommendation to the Board.

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

1. the community and patient need;
2. the capacity of the Hospital to support the new privilege(s) requested, including whether appropriate equipment, space, supplies, trained staff, scheduling and other necessary resources are reasonably available;
3. quality of care issues;
4. patient convenience;

5. reimbursement issues; and
6. any other business and patient care objectives of the Hospital which the Board believes are relevant to disposition of the request.

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

G. GENERAL GUIDELINES • The following guidelines will be used in the development of privileging criteria. The purpose is to define the training, competence and experience required to perform the requested clinical privilege(s). An approved Privilege Criteria/Request form is attached hereto as Appendix A, for illustrative purposes. (Rev. 10/06)

1. the type of basic education (degree) required to apply for the privilege(s) in question;
2. whether the medical staff member must be board certified/eligible;
3. the type and extent of formal training, such as type of residency, fellowship or other type of training;
4. how much recent practice experience (within the past 12-24 months) in the practice area or related field the medical staff member or medical staff member must demonstrate;
5. any continued didactic or hands-on training; either that is required;
6. number and types of references that will be necessary to evaluate the Medical staff member or medical staff member's ability, judgment and current clinical competence; and
7. special proctoring requirements or other criteria that the ad hoc committee, department/clinical section/committee, medical staff member feels is appropriate.

H. EDUCATIONAL GUIDELINES • The following educational guidelines apply unless otherwise specified. (Rev. 6/03)

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

ARTICLE XIII

IMPAIRED PHYSICIANS

SECTION 1. PURPOSE

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

SECTION 2. DEFINITION

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

SECTION 3. PROCEDURE FOR REPORT AND INVESTIGATION

- A. REPORT • If any individual has reasonable suspicion that a Practitioner is impaired, such person will provide a written report to the President or President Elect of the Medical Staff, the chairperson of the Practitioner’s department, or the Medical Director, Physician Relations. The report does not have to include conclusive proof of impairment, but will include a factual description of the incident(s) that led to the person’s concern.
- B. INITIAL REVIEW • After receipt of a report concerning a Practitioner’s potential impairment, the recipient will evaluate whether it appears there is sufficient evidence to warrant further investigation. If so, the President of the Medical Staff, or his/her designee, may:
 - 1. meet personally with the Practitioner; and/or
 - 2. refer the report for investigation to an appointed investigator.
- C. INVESTIGATOR • For the purposes of this policy, the Investigator will be assigned by the Medical Staff President and may include a Medical Staff Leader, Department Chair, Ad Hoc Committee or the Physician Professional Practice Committee. (Added 6/06)
- D. INVESTIGATION • The investigation of a Practitioner’s potential impairment may include, but is not limited to, any of the following:

1. an interview with the Practitioner;
2. the review of any and all documents or other materials relevant to the investigation and the Practitioner's potential impairment;
3. interviews with any and all individuals involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made are related to the performance of the Practitioner's clinical privileges or scope of practice consistent with proper patient care at the Hospital, and that confidentiality is maintained;
4. the requirement that the Practitioner undergo a complete medical examination (including a psychiatric evaluation, if appropriate) as directed by the appointed Investigator, provided the exam is related to the performance of the Practitioner's duties and privileges; and/or
5. a requirement that the Practitioner submit to a drug test/screening, in compliance with the Idaho Code, if appropriate to the potential impairment. (Rev. 6/06)

SECTION 4. CLASSIFICATION OF IMPAIRMENT

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

SECTION 5. RECOMMENDATION

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

SECTION 6. COMMUNICATION OF INVESTIGATION

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

SECTION 7. CONFIDENTIALITY/DOCUMENTATION OF INVESTIGATION

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

SECTION 8. NO ABUSE OF POLICY

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

SECTION 9. IMPAIRMENT CLASSIFIED AS A DISABILITY UNDER THE ADA

- A. REASONABLE ACCOMMODATION • If the Practitioner’s impairment is a disability under the ADA, a determination by the Investigator, in consultation with legal counsel, will be made as to the following:
1. whether a reasonable accommodation may be made such that the Practitioner would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of his or her medical staff appointment;
 2. whether such reasonable accommodation would create an “undue hardship” upon the Hospital in that the reasonable accommodation would be excessively expensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital’s operations or the provision of patient care; and
 3. whether the impairment constitutes a “direct threat” to the health or safety of the Practitioner, patients, staff or others within the Hospital. A direct threat must involve a significant risk of substantial harm based upon medical analyses and/or other objective evidence. If the Practitioner appears to pose a direct threat because of a disability, the Investigator must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.
- B. VOLUNTARY AGREEMENT • If it is determined that a reasonable accommodation may be made as described above, attempts will be made to work out a voluntary agreement with the Practitioner, so long as the arrangement would neither constitute an undue hardship upon the Hospital or create a direct threat, also as described above. The Chief Executive Officer will approve any agreement before it becomes final and effective.
- C. OTHER RECOMMENDATION • If the Hospital is unable to make a reasonable accommodation or if a voluntary agreement cannot be reached with the Practitioner, the Investigator, via the Medical Executive Committee, will make a recommendation and report to the Board of Trustees, through the Chief Executive Officer, as to appropriate action to be taken. If the Investigator’s recommendation would provide the Practitioner with a right to a hearing as described in the Medical Staff Bylaws, the Chief Executive Officer will promptly notify the Practitioner of the recommendation in writing, by certified mail, return receipt requested. The recommendation will not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the Medical Staff Fair Hearing Plan.(Rev. 6/06)

SECTION 10. IMPAIRMENTS THAT ARE NOT DISABILITIES UNDER THE ADA

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

SECTION 11. REHABILITATION AND REINSTATEMENT

- A. PRACTITIONER RECOVERY NETWORK • If appropriate, the impaired Practitioner will be referred to the Idaho Medical Association Practitioner Recovery Network (PRN), which will assist the Practitioner in locating a suitable rehabilitation program. The Practitioner may be placed on a medical leave for purposes of participation in the program. A Practitioner will not be reinstated until it is established, to the Hospital's satisfaction, that the Practitioner has successfully completed a PRN-sanctioned program.
- B. ELIGIBILITY FOR REINSTATEMENT • Upon sufficient proof that a Practitioner who has been found to be suffering from impairment has successfully completed a PRN-sanctioned rehabilitation program, the Hospital at its discretion, may consider that Practitioner eligible for reinstatement to the Medical Staff. Sufficient proof includes but is not limited to a letter from the director of the rehabilitation program where the Practitioner was treated confirming that:
1. The Practitioner participated in the program;
 2. The Practitioner is in compliance with all of the terms of the program;
 3. Whether, in the director's opinion, the Practitioner is capable of resuming medical practice and providing continuous, competent care to patients; and
 4. Whether, in the opinion of the director, the Practitioner should participate in an aftercare program.
- C. REINSTATEMENT • In considering an impaired Practitioner's eligibility for reinstatement, the Hospital must make a decision in the best interest of patient care. Assuming all of the information received indicates that the Practitioner is rehabilitated and capable of resuming care of patients, the following additional precautions should be taken when restoring clinical privileges, the Practitioner:
1. must identify another Practitioner who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability;
 2. will be required to obtain periodic reports from his or her primary treating physician or psychologist or monitoring physician for a period of time specified by the Chief Executive Officer, President and the President Elect of the Medical Staff, verifying that the Practitioner is continuing treatment or therapy, and that his or her ability to treat and care for patients in the Hospital is not impaired;
 3. exercise of clinical privileges in the Hospital will be monitored by the department chairperson or designee; and
 4. must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Medical Staff President or the chairperson of the Practitioner's department.

SECTION 12. AFTER-CARE PROGRAMS

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

ARTICLE XV

CONDUCT

SECTION 1. PURPOSE AND PHILOSOPHY STATEMENT

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

SECTION 2. DEFINITIONS

- A. SEXUAL HARASSMENT • It is a violation of both state and federal law for a Hospital employee to be subjected to sexual harassment in the workplace. Sexual harassment, as prohibited by law, is distinguished from a voluntary sexual relationship by the elements of coercion, threat, unwanted attention, unwelcome or unwanted sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Verbal or physical conduct of a sexual nature constitutes sexual harassment when any of the following things occur:
1. Submission to or rejection of such conduct is either implicitly or explicitly made a term or condition of employment or participation in Hospital activities.
 2. Submission to or rejection of such conduct by an individual is used as a basis for evaluation in making personnel decisions affecting an individual.
 3. Conduct unreasonably interferes with the performance or work of the individual or creates an intimidating, hostile or offensive work environment.
- B. DISRUPTIVE CONDUCT • For purposes of this policy, disruptive conduct includes, but is not limited to, any of the following:
1. Using threatening or abusive language directed at an individual or regarding another individual, including patients, nursing staff, other Hospital personnel or Practitioners (e.g., belittling, berating and/or threatening an individual).
 2. Making degrading, demeaning or insulting comments regarding patients, nursing staff, other Hospital personnel or the Hospital.
 3. Using profanity, racial slurs or similarly offensive language.

4. Verbal, non-verbal or physical interaction with another individual that is reasonably perceived as threatening, intimidating or disruptive to the orderly operations of the Hospital.
5. Addressing concerns about clinical judgment or dissatisfaction with the performance of another individual in the medical record or by other inappropriate means (instead of through direct and professional contact with the individual or through Medical Staff or Hospital policies).
6. Refusing to utilize the electronic health record or any informational technology required for safe patient care or refusing to participate in training associated with the electronic health record or any informational technology required for safe patient care.

SECTION 3. SCOPE OF POLICY

- A. PLACE OF CONDUCT THAT MAY VIOLATE POLICY • This policy is intended to address conduct that occurs within the Hospital. However, if the conduct is egregious or could adversely affect the collegial atmosphere and orderly operations of the Hospital, even if the conduct occurs outside the Hospital or clinical setting, the Medical Staff may choose to invoke this policy.
- B. APPLICATION TO COMPLAINTS ABOUT PRACTITIONERS • This policy applies to complaints of unlawful harassment or disruptive behavior made by patients, Hospital employees, Practitioners or others about any Practitioner. Complaints about the conduct of Practitioners, including Hospital-employed Practitioners, will be handled in accordance with this policy. Complaints about the conduct of other Hospital employees will be handled in accordance with the Hospital's applicable Human Resource Policies and Procedures.
- C. CORRECTIVE ACTION • This policy outlines a collegial procedure to attempt to address disruptive or unlawful harassing conduct by a Practitioner, and invoking the policy does not itself entitle a Practitioner to rights under the Bylaws' Fair Hearing Plan. However, notwithstanding the Medical Staff's desire to try to address these issues through the collegial procedure in this policy, this policy does not preclude immediate invoking of the Bylaws' Corrective Action Plan process at any time, if it is determined that the Practitioner's conduct so warrants. For example, if there is a single severe incident of conduct, or a repetitive pattern of conduct that is egregious, this collegial procedure may be bypassed, and the Corrective Action Plan may be invoked. (If the Corrective Action Plan is invoked and the Practitioner's conduct results in an adverse action as defined in the Bylaws, then the Practitioner would be entitled to such rights as are outlined in the Fair Hearing Plan.)
- D. PEER REVIEW CONFIDENTIALITY • The Investigation of a Practitioner under this policy is considered and intended by the Hospital and Medical Staff to be within the scope of Peer Review confidentiality as provided under Idaho Code Section 39-1392 et. seq. and Bylaws Article VII, Section 3.

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

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

guidelines in this policy.

- B. Event Report Triage Committee. All incident reports/complaints, and other complaints received through other sources regarding Practitioners will be reviewed by the Risk Management Department and the President of the Medical Staff to verify basic information. Complaints which require further review and investigation will initially be evaluated and triaged by a committee composed of the Chief Medical Officer, Vice President Quality and Patient Safety and/or a representative from the Office of Medical Affairs (“OMA”), the Director of Nursing Operations, the President, President-elect or Secretary/Treasurer of the Medical Staff, the President of Hospital or his or her designee, and the Director of Risk Management or designee.
- C. General Triage Guidelines. Issues are generally triaged by the Event Report Triage Committee as follows and may be forwarded as listed below:
- All anonymous reports/complaints are retained for tracking and trending. Anonymous reports/complaints will be assessed by the Event Report Triage Committee and may be referred for such investigation as is possible to undertake under the circumstances.
 - Reports/complaints that are evaluated as predominantly a result of system issues and involve a Practitioner who rarely has complaints filed against him or her may be referred to the manager of the area where the complaint occurred for further investigation and resolution.
 - Reports or complaints may be forwarded to the Practitioner's Department Chair.
 - Reports/complaints that are evaluated as predominantly system issues may be referred to other Committees or individuals (such as the manager of the area where the incident occurred) for follow up and or disposition.
 - Reports/complaints that are deemed to potentially involve a quality of care component may be also forwarded for peer review.
 - Reports/complaints that involve a Practitioner who has numerous or repetitive complaints may be referred to the PPPC.
 - Any reports/complaints of egregious behavior, no matter the frequency of the complaints against the Practitioner, are referred to OMA for distribution to the Chair of the PPPC, the President and President-elect of the Medical Staff, the Chief Medical Officer, Vice President Quality and Patient Safety, the CEO, or their respective designees. Complaints of unlawful harassment involving hospital employees including employed Practitioners, will also be referred to the Manager of Employee Relations or other appropriate designee of Human Resources.
- C. Practitioner Notification. The Chair of the PPPC will inform the Practitioner of the receipt of the report/complaint within a reasonable time after receipt and whenever possible within seven (7) days of the completion of the review of the complaint by the Event Report Triage Committee. The Practitioner may review the complaint in the OMA after acknowledging the Medical Staff policy prohibiting retaliation against the Complainant, as more specifically set forth in Section 10 of this policy. No copies of the documentation will be made by or for the Practitioner. The complaint and accompanying documentation may not be removed from the OMA by the Practitioner.

SECTION 5: FURTHER EVALUATION OF REPORT/COMPLAINT

- A. Referral to the PPPC or other Investigator. The Event Report Triage Committee will consider whether it is appropriate to attempt to address and resolve the issue at an informal level directly

with the Practitioner, or if further investigation is warranted. The President-Elect of the Medical Staff may also notify the Department Chair and decide the type of involvement in the investigation for the Department Chair based on the report/complaint.

1. When evaluating how to proceed, the Event Report Triage Committee will consider the facts and circumstances alleged, including but not limited to the severity and frequency of the complained of conduct, information available that verifies the conduct (such as witnesses reports confirming the conduct), any prior complaints about the Practitioner and the Practitioner's attitude and willingness to professionally address the concerns raised, if known.
2. If the Event Report Triage Committee determines the matter cannot be or was not able to be resolved informally, or if it is a repeated incident or an egregious incident, or number of incidents, the Event Report Triage Committee will forward the complaint to the PPPC or another appropriate investigator(s) ("Investigator") to complete a review of the report/complaint and conduct an investigation. Alternatively, if the Event Report Triage Committee feels the allegations warrant, it may refer a matter to one of the individuals listed in the Bylaws for precautionary suspension and/or initiation of an investigation under the Corrective Action Plan. If that occurs, the process outlined in that Corrective Action Plan will then apply to the review of the matter, rather than this policy.
3. Risk Management, the Event Report Triage Committee or PPPC will investigate most complaints; however, if another Investigator is chosen, consideration will be given to the source of the report/complaint. For example, an employee report/complaint could be investigated by the HR Employee Relations Manager or designee, a Practitioner complaint could be investigated by a Department Chair, and a patient complaint could be investigated by the appropriate nursing leader or by a designated members of the PPPC).

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

C. Investigation Process.

1. The Investigator(s) will conduct as thorough of an investigation as possible, in a manner that is reasonably confidential under the circumstances. Whenever feasible, the Investigator will conduct the investigation within ten (10) business days of receiving the report/complaint from the Event Report Triage Committee or as soon as is reasonably possible.
2. The investigation will include interviews with any witnesses and discussions with both the Complainant and the Practitioner, who will be advised of the contents of the complaint and be given an opportunity to respond to the allegations.
3. The Investigator will determine whether the complained of conduct occurred or likely occurred. The Investigator will prepare a written report and summary of the investigation and provide it to the PPPC. The Investigator may also be asked to meet with the PPPC Chair or its members to answer questions regarding the report and conclusions.
4. If the Investigator finds that in his or her judgment the weight of the evidence is that the complained of conduct has occurred and this policy has been violated, he or she will inform the PPPC and the matter will proceed as outlined in Section 6.
5. If the Investigator finds that in his or her judgment the weight of the evidence is that the complained of conduct did not occur and/or did not violate this policy, the PPPC will be so advised and the Complainant and the Practitioner will be notified in writing by the PPPC

Chair. If there is information which may indicate that other policies have been violated then the PPPC will make a referral for further investigation and action to other appropriate Medical Staff or Hospital bodies.

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

1. If the Investigator determines there has been a policy violation, the Practitioner will be required to meet with the PPPC and any other appropriate individuals invited by the PPPC Chair.
2. The Chair of the PPPC will inform the Practitioner of the findings of the Investigation at the meeting and will give the Practitioner an opportunity to respond at this required meeting.
3. The Practitioner may review all the documentation in the OMA, but he or she may not copy the documentation. He or she will also be reminded of the “no retaliation” policy set forth in Section 10 below. If the Practitioner does not present additional information which convinces the majority of the PPPC members present that he or she did not violate this policy, the Practitioner will be informed by the PPPC Chair of this conclusion. He or she will also be informed of the remedial action which will be imposed (unless the PPPC needs to undertake further deliberation regarding the matter). The PPPC will write a formal notification to the Practitioner. In The final findings and written notification to the Practitioner by the PPPC Chair should be completed within seven (7) calendar days after the meeting with the Practitioner. If the Practitioner wishes to submit a written response to the meeting, the written response must be received in OMA within forty-eight (48) hours of the conclusion of this final meeting with the Practitioner.
4. Any documentation regarding the investigation, including the Investigative Report, and the PPPC Chair’s notification of the Practitioner’s findings of the Investigation will remain in the OMA in the Practitioner’s Professional Practice File. The investigation documentation is considered peer review protected information under Idaho Code section 39-1392 and will remain as confidential as possible to the extent permitted by law and the Bylaws.
5. In addition to informing the Practitioner as set forth above, at the conclusion of the investigation, the PPPC Chair will notify the Complainant in writing that the matter was investigated and if applicable, may generally state that remedial action has been taken (without indicating the specific action taken). The President of the Medical Staff, Chief Medical Officer, Vice President Quality and Patient Safety and the Hospital CEO should be copied on the final notification to the Practitioner and the Complainant.

SECTION 7: REMEDIAL OPTIONS FOR POLICY VIOLATIONS

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

and the effect of the remedial measures in ensuring the complained of conduct ceases and does not reoccur.

1. Verbal Warning. Requiring that the Practitioner cease the conduct which gave rise to the complaint.
2. Written Warning. Letters of admonishment, reprimand or warning, requiring that the Practitioner cease the conduct that gave rise to the complaint.
3. Suspension: Suspension for one (1) to fourteen (14) days of all or a portion of the clinical privileges of the Practitioner.
4. Counseling, Education and Training. A requirement that the Practitioner attend specified counseling or education and training regarding sexual harassment or sensitivity, anger management, other appropriate counseling, education and training including referral to the Idaho Physicians' Recovery Network or other appropriate referral for follow-up approved by the PPPC.

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

SECTION 8. NO ABUSE OF POLICY TOLERATED

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

SECTION 9. NO RETALIATION POLICY

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

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

SECTION 10. REAPPOINTMENT

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

ORGANIZATION MANUAL

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CHAPTER I

MEDICAL STAFF DEPARTMENTS

The Medical Staff will be organized into the following departments:

- A. MEDICINE • Including Dermatology and Physical Medicine & Rehabilitation;
- B. GENERAL, VASCULAR, & THORACIC SURGERY •;
- C. SURGICAL SUBSPECIALTIES • Including Ophthalmology, Otorhinolaryngology, Plastic Surgery, Urology, Oral & Maxillofacial Surgery, and Dentistry;
- D. OBSTETRICS & GYNECOLOGY •;
- E. FAMILY MEDICINE •;(Rev. 2/05)
- F. ORTHOPAEDICS • Including Podiatrists and Clinical Neurophysiologists;
- G. NEUROLOGY & NEUROSURGERY •;
- H. PSYCHIATRY & PSYCHOLOGY •;
- I. PEDIATRICS •;
- J. CARDIOLOGY & CARDIAC SURGERY •;
- K. PATHOLOGY •;
- L. ANESTHESIA •;
- M. RADIOLOGY •;
- N. EMERGENCY MEDICINE•; and
- O. AMBULATORY STAFF

CHAPTER II

FUNCTIONS OF DEPARTMENTS

SECTION 1. PEER REVIEW

Each department will be responsible for conducting a review of pertinent departmental sources of medical information relating to quality and appropriateness of patient care. Such review will be conducted not less than four (4) times per year for the purpose of monitoring and evaluating the quality and appropriateness of the care and treatment of patients by individuals with clinical privileges in that department and to monitor adherence to the Medical Staff Bylaws and policies and procedures. Each department will maintain a record that includes the conclusions, recommendations, and actions pertaining to such monitoring and evaluation.

SECTION 2. PRIVILEGING AND CREDENTIALING

Each department will recommend objective qualifications and criteria for granting and reviewing clinical privileges of practitioners within the department, generally and where appropriate, for specific procedures. In those circumstances where clinical problems are managed by more than one department, separately or in a multidisciplinary approach, each department will coordinate and cooperate with other departments so that credentialing criteria for the various departments is uniform and consistent. The Medical Executive Committee and the Board will approve all credentialing criteria.

SECTION 3. DEPARTMENT POLICIES AND PROCEDURES

Each department will establish and maintain policies and procedures in keeping with objectives of the Board. When the hospital pursues and establishes accreditation for clinical programs, departments will establish and maintain policies which define the participation of individuals with clinical privileges in that department required to secure and maintain program accreditation.

Those policy matters exclusively related to Saint Alphonse Medical Group Clinical Care, Process Improvement and Peer Review are delegated to the Saint Alphonse Medical Group Leadership Council.

SECTION 4. PROBLEMS

Each department will review problems of medical care and disciplinary problems that arise within the department. Each department will, as much as feasible and practical under the circumstances, handle minor problems in discipline, behavior and conduct of its members by informal meeting and persuasion. Whenever a major problem arises and one which points to the possible need for disciplinary action, and whenever informal meetings and persuasion seem ineffective, a written report and recommendation will be made by the chair and forwarded to the Medical Executive Committee.

SECTION 5. CONTINUING PROFESSIONAL EDUCATION

Each department will conduct and participate in and make recommendations regarding the need for continuing professional education programs.

SECTION 6. CONSULTATIONS

- (a) Any individual with clinical privileges at this Medical Center may be requested to provide a consultation within his or her area of expertise.
- (b) The attending Medical Staff member shall be responsible for requesting a consultation when indicated.
- (c) Requests for a consultation shall be entered in the patient's medical record. For consults, the physician could write for the consult in the patient's medical record to include 1) reason for the consult, 2) level of participation, 3) priority, 4) additional instructions/comments and 5) physician notified, and 6) contact number in case consultant needs to contact him/her. If the history and physical are not part of the patient's medical record and the documentation has not been completed, it shall be the responsibility of the Medical Staff member requesting the consultation to provide this information to the consultant.
- (d) Request for consultation may be direct physician-to-physician communication through a phone call or other direct communication for all consultations unless communication between the providers has been established on that patient prior to the consultation. It is also acceptable to have an advance practice clinician to the physician provide this communication or receive this communication as the representative of the physician.
- (e) In circumstances of grave urgency, or where consultation is required by these Rules and Regulations or imposed by the MEC, the Board, the President, the CMO, or the President of the Medical Staff, the appropriate clinical department chairperson shall at all times have the right to call in a consultant or consultants.

Required Consultations:

- (a) As determined by available resources of the hospital, consultations are required for complicated situations that require specific skills of other practitioners; or
- (b) Mandatory Consultations:
 - i. When, as a result of peer review activities, a consultation requirement is imposed by the MEC or the Board, pursuant to the Medical Staff Credentials Policy, the required consultation shall not be rendered by an associate or partner of the attending Medical Staff member.
 - ii. Failure to obtain required consultations may result in a further professional review action pursuant to the Medical Staff Manual.

Contents of Consultation Report:

- (a) Each consultation report shall be completed within a calendar day and shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," shall not constitute an

acceptable consultation report. The consultation report shall be made a part of the patient's medical record.

(b) Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's medical record prior to the surgical procedure. The consultation report shall contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the signature of the consultant.

SECTION 7. EMERGENCY CALL

Each department will establish qualifications and responsibilities as to emergency call duties for each member of the department. The department will be responsible for providing continuous emergency call coverage throughout the hospital. Annually, each department will submit to the Medical Executive Committee for review and approval an emergency call plan. The plan will include voluntary and mandatory rosters and the qualifications required to serve on each.

SECTION 8. HAND-OFFS

All clinical areas will have an identified hand-off policy to include at a minimum the patient's name, where located, why they are in the hospital, acute events since the last hand-off or shift and any follow up issues.

SECTION 9. DEPARTMENT MANUAL

Each department will maintain and have readily available a department manual containing copies of all rules, regulations, procedures, call requirements, credentialing criteria, peer review criteria and other information applicable to the department and its members.

CHAPTER III

SUPERVISORY COMMITTEES

SECTION 1. POLICY

The department, with the approval of the Medical Executive Committee and the Board will establish a Supervisory Committee for each department. The Supervisory Committee will consist of the chair, chair-elect of the department and Clinical Section chairs, if they exist or 3 to 5 at-large members appointed by the department chair. The chair of the department will act as the chair of the Supervisory Committee. Each member will serve a two (2) year term.

SECTION 2. DUTIES

The Supervisory Committee will perform all of the duties and functions of the department delegated to it by the department. The duties and functions of a Supervisory Committee will be set forth in writing and reviewed annually by the department. It is the responsibility of the Supervisory Committee to communicate its actions and decisions to all department members.

CHAPTER IV

CLINICAL SECTIONS

SECTION 1. POLICY

Clinical sections for a department may be established by the department, with the approval of the Medical Executive Committee and Board. Each clinical section will elect a chair.

SECTION 2. DUTIES

The clinical section will assist the department chair, in the performance of his or her duties, as requested.

CHAPTER V

STANDING COMMITTEES

SECTION 1. COMMITTEES

- A. Policy
- B. Reporting

If not specifically outlined, each committee will report actions affecting the Medical Staff to the next upcoming Medical Executive Committee for review. A minimum of one written report to Medical Executive Committee per year is required.

The Medical Staff, in conjunction and cooperation with the Hospital clinical and administrative staff, and subject to Board approval, will provide effective mechanisms to monitor and evaluate the quality and appropriateness of all patient care and the clinical performance of all individuals with delineated Clinical Privileges. These mechanisms will provide a means by which important problems in patient care can be identified and resolved and opportunities for improve care can be addressed.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee composition and responsibilities are defined in the Medical Staff Bylaws.

SECTION 3. CREDENTIALS COMMITTEE

- A. COMPOSITION • The Credentials Committee will consist of the following:
 - 1. 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.
 - 2. 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.
- B. APPOINTMENTS • The Medical Staff President will appoint one (1) member to the committee each year, for a term of five years.
- C. 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.
- D. VACANCIES • Upon notice of medical staff privilege resignation, the President of Medical Staff will appoint a successor to carry out role.
- E. 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.

F. DUTIES • The Credentials Committee will:

1. review the credentials and qualifications of all Applicants, to make such investigations of and interview Applicants as may be necessary, to obtain and consider the recommendations of the departments in which an Applicant seeks appointment, and to make recommendations for appointment, reappointment and delineation of clinical privileges;
2. make a report to the Medical Executive Committee on each Applicant for Medical Staff appointment and clinical privileges, including recommendations with regard to the appointment or reappointment, staff status, department affiliation and any special considerations or conditions; and
3. review, on their own motion or at the request of the Medical Staff President, the Medical Executive Committee, the Quality and Safety Council, or any other Medical Staff or Board committee responsible for monitoring quality patient care, all questions regarding the professional and clinical competence of persons currently appointed to the Medical Staff, their care and treatment of patients and case management, their compliance with the Medical Staff Bylaws, or their ethical conduct, and as a result of such review, to make recommendations to the Medical Executive Committee for the granting, reduction or withdrawal of clinical privileges or staff membership. ^(rev 2/08)

G. REPORTING • The Chair of the Credentials Committee, or designee, will meet with the Medical Executive Committee or Board, or their applicable committees, on all recommendations that the Credentials Committee may make to increase direct communication between the Medical Executive Committee and the Credentials Committee on all matters within the scope of the Credentials Committee's duties and to afford the Board the opportunity to communicate directly with the Credentials Committee.

H. MEETINGS AND RECOMMENDATIONS • The Credentials Committee will meet as often as necessary to accomplish its duties, but at least four (4) times a year, and will maintain a permanent record of its proceedings and actions and will report its recommendations to the Medical Executive Committee.

SECTION 4. BYLAWS COMMITTEE

A. COMPOSITION • The Bylaws Committee will consist of:

1. at least five (5) persons appointed from the active staff;
2. the Secretary-Treasurer of the Medical Staff will be a member of the committee and will serve as the chair; and
3. the Bylaws Committee may also include, as Ex Officio members, such representatives from the Hospital administration.

B. DUTIES • The Bylaws Committee will:

1. review the Bylaws and Rules and Regulations of the Medical Staff and recommend amendments thereto to the Medical Executive Committee on an annual basis;
2. receive and consider all recommendations for changes in these Bylaws by the Board, the Medical Executive Committee of the Medical Staff, the departments, the President of the Staff, the Chief Executive Officer, committees of the Medical Staff and any individual appointed to the Medical Staff;
3. they will particularly examine and propose amendments to correct conflicts and inconsistencies;

4. maintain a permanent record of its activities;
- C. MEETINGS • The Bylaws Committee will meet as often as necessary, but at least annually, to fulfill its duties.

SECTION 5. BIOETHICS COMMITTEE

- A. COMPOSITION • The Bioethics Committee will include medical staff and non-medical staff members.
- B. CHAIR • The Medical Staff President in conjunction with the Hospital staff appoints the Chair.
- C. DUTIES • The specific duties and functions of the Bioethics Committee will:
1. direct and conduct educational programs on biomedical issues;
 2. provide a forum for discussion among hospital and medical professionals and others about bioethical issues;
 3. serve in an advisory capacity or as a resource to people involved in biomedical decision making;
 4. evaluate institutional experiences related to reviewing decisions having biomedical-ethical implications;
 5. formulate and review policies and procedures concerning bioethical issues;
 5. maintain a permanent record of its findings, proceedings and actions;
- D. MEETINGS • The Bioethics Committee will meet at least four (4) times per year.

SECTION 6. INSTITUTIONAL REVIEW BOARD

- A. PURPOSE • Human Subjects Research performed at Saint Alphonsus will be approved, reviewed, and monitored by a qualified Institutional Review Board (IRB). The IRB will either be internal (Saint Alphonsus IRB) or Saint Alphonsus will maintain a Reliance Agreement with an external IRB.
- B. COMPOSITION • The IRB, whether internal or external, will consist of at least five (5) qualified members from multiple professions, of both sexes, and with diverse and varying backgrounds to promote a complete and adequate review of research activities commonly conducted by the institution. The composition of an external IRB will be reviewed by the Research Administrator and Institutional Official (if necessary) to ensure compliance. The varying backgrounds of members must include at least one member whose primary concern is:
1. in the scientific area;
 2. in the non-scientific area; and
 3. not otherwise affiliated with the institution and is not an immediate family member of someone who is affiliated with the institution.
- C. CHAIR • The IRB Chair is appointed by the Institutional Official listed on the Federal Wide Assurance (FWA) document.
- D. DUTIES • The specific duties and functions are:

1. review and evaluate all investigational plans and to determine that the investigational plan or study provides a benefit such that the risk for the subjects is justified;
2. assure that the rights of human subjects are properly protected and that legally effective informed consent is obtained and that the method of obtaining consent properly informs the human subject of the significant aspects of the study;
3. review all investigators and to evaluate the training and experience of the investigator to ensure that it is appropriate to qualify the investigator to conduct the study;
4. maintain a permanent record of its findings, proceedings and actions

E. MEETINGS • The Institutional Review Board will meet as necessary

SECTION 7. OPERATING ROOM COMMITTEES

A. OPERATING ROOM EXECUTIVE COMMITTEE (OREC) • (Added 10/06)

1. COMPOSITION. The Operating Room Executive Committee will include:
 - a. Medical Director of Anesthesiology;
 - b. Medical Director of Operative Services (a surgeon selected by the Saint Alphonsus Regional Medical Center Chief Executive Officer with the approval of the Medical Staff President);
 - c. Director of Perioperative Services;
 - d. Operating Room Business Manager; and
 - e. Hospital Vice President in charge of the Operating Room Program.
2. CHAIR. The Chair of the OREC will be the Medical Director of Operative Services.
3. DUTIES. The OREC will serve as a proactive, decision-making group for all of Perioperative Services. The specific duties and functions of the OREC are:
 - a. implementation and monitoring of service line programs;
 - b. supervision of Operating Room Control Desk management;
 - c. supervision and management of the perioperative process including:
 - 1) pre-surgical screening;
 - 2) surgery same day admission process;
 - 3) post-anesthesia recovery; and
 - 4) anesthesiology preoperative process.
 - d. overall direction of the Operating Room capital budget process;
 - e. set direction and review the performance of the surgery program;
 - f. coordinate all allocations for Operating Room block time;
 - g. disseminate information to, and solicit recommendations and assistance from the Operating Room Committee; and
 - h. coordinate and oversee activities of the Operating Room Patient Safety Committee.
4. MEETINGS. The OREC will meet as needed to fulfill its duties.
5. AUTHORITY. All decisions of the OREC will become operative immediately unless modified by the Medical Executive Committee and/or by appropriate Hospital management.

B. OPERATING ROOM COMMITTEE •

1. COMPOSITION. The Operating Room will include:
 - a. one medical staff member from the following areas:
 - 1) Anesthesiology;
 - 2) Cardiac Surgery;
 - 3) Neurosurgery;

- 4) General, Vascular & Thoracic Surgery;
 - 5) Obstetrics & Gynecology;
 - 6) Orthopaedic Surgery; and
 - 7) Surgical Subspecialties.
- b. members of the OREC;
 - c. Director of Perioperative Services;
 - d. Senior Hospital administration representative; and
 - e. Other Hospital personnel attending as ex-officio members, as needed.
2. CHAIR. The Chair of the Operating Room Committee will be appointed by the Medical Staff President.
 3. DUTIES: The specific duties and functions of the Operating Room Committee are:
 - a. review, evaluate and disseminate information regarding the operation and maintenance of the operating rooms to their respective departments;
 - b. make recommendations to the OREC;
 - c. assist in implementing new programs, procedures and policies for the surgery program;
 - d. provide input and review all allocations for operating room block time for each service and surgeon;
 - e. review patient safety and regulatory issues pertinent to the operating room;
 - f. maintain a permanent record of its findings, proceedings and actions to be presented monthly to the Medical Executive Committee;
 - g. provide input and review requests for operating room capital expenditures; and
 - h. participate and assist in the implementation of operating room policies and procedures at the behest of the OREC.
 4. MEETINGS. The Operating Room Committee will meet as needed to fulfill its duties.
 5. AUTHORITY. The Committee will function as a review and advisory body to the OREC and will communicate with its respective departments.

SECTION 8. CANCER COMMITTEE

- A. COMPOSITION • The Cancer Committee is a standing committee with membership as listed below:
 1. Physician members must include a diagnostic radiologist, pathologist, general surgeon, medical oncologist, radiation oncologist, Cancer Committee Chair AND Cancer Liaison Physician (CLP);
 2. Non-physician members must include the Cancer Program administrator, oncology nurse, social worker or case manager, certified tumor registrar and performance improvement professional required coordinators and;
 3. Other members may include, but are not limited to specialty physicians representing the major cancer experiences at the hospital, dietary/nutrition specialist, genetics professional, pharmacist, rehabilitation services representative, pastoral care representative, psychiatric or mental health professional, nurse navigators and American Cancer Society representative.
- B. CHAIR • The Cancer Committee Chair is appointed by the Medical Staff President with recommendations received from the Cancer Committee. (Rev. 4/05)
- C. PROGRAM ACTIVITY COORDINATORS • A physician member, or where approved, a staff member, shall be assigned as program activity coordinators for the following: (Added. 4/07)
 1. Cancer Conference Coordinator
 2. Quality Improvement Coordinator

3. Cancer Registry Quality Control Coordinator
4. Clinical Research Coordinator
5. Psychosocial Services Coordinator
6. Survivorship Program Coordinator

- D. DUTIES • The Cancer Committee is responsible for: (Rev. 4/05)
1. developing and evaluating the annual goals and objectives for the clinical, educational, performance improvement and programmatic activities related to cancer;
 2. promoting a coordinated, multidisciplinary approach to patient management;
 3. ensuring that educational and consultative cancer conferences cover all major sites and related issues;
 4. ensuring that an active supportive care system is in place for patients, families, and staff;
 5. promoting clinical research;
 6. monitoring the reports of the cancer registry to ensure accurate and timely abstracting, staging, and follow-up reporting; and
 7. upholding medical ethical standards.

- E. MEETINGS • The Cancer Committee meets quarterly.

SECTION 9. PHARMACY AND THERAPEUTICS COMMITTEE (Added section 5/04)

- A. PURPOSE • The P&T committee will be responsible for optimizing medication therapy at Saint Alphonsus Regional Medical Center. The committee will:
1. monitor the outcomes of the medication use process including prescribing, dispensing, administering, and monitoring;
 2. monitor the financial impact of medication use. This includes utilizing pharmaco-economic analyses of medications added to the formulary to project the drug and non-drug cost impacts; and
 3. identify and implement changes to improve the clinical and economic outcomes of medication use.
- B. COMPOSITION • The Pharmacy and Therapeutics Committee will be a multidisciplinary committee consisting of:
1. at least five (5) members of the active Medical staff;
 2. Director of Pharmacy Services, Ex-Officio (Rev. 5/04)
 3. Pharmacy Clinical Coordinator, Ex-Officio (Rev. 5/04)
 4. a representative from the Nursing Department, Ex-Officio;
 5. Infection Control Program Coordinator, Ex-Officio;
 6. a representative from Performance Improvement Program, Ex-Officio;
 7. Medication Safety Program Coordinator, Ex-Officio;
 8. a representative from Nutrition Service, Ex-Officio;
 9. a representative from Administration, Ex-Officio; and
 10. Other members of both the medical and hospital staff may attend on an Ex-officio basis.
- C. VACANCIES • The Medical Staff President will appoint the committee chairman and physician members to the committee.
- D. ADMINISTRATIVE SUPPORT • The Pharmacy Clinical Coordinator serves as secretary of the committee and is responsible for the preparation of the agenda and distribution of the committee minutes.

- E. ETHICS • Members of the Pharmacy & Therapeutics Committee, including subcommittees, must complete an annual conflict of interest disclosure and abide by the requirements as specified in the conflict of interest policy.
- F. MEETINGS • The committee will meet as often as necessary but at least six times annually.
- G. AUTHORITY •
1. The committee will function as a decision making body to the medical staff on matters pertaining to the evaluation, appraisal, selection, procurement, storage, distribution, appropriate use, safety, and all other matters relating to drugs in the Hospital.
 2. It will maintain a record of its proceedings and will report its activities for information only to the Medical Executive Committee as well as the Performance Value Council.
- H. DUTIES • The Pharmacy & Therapeutics Committee will:
1. Recommend professional policies regarding all aspects of the medication use process. This includes evaluation, selection, procurement, storage, distribution, handling, appropriateness of use, cost effectiveness, safety, administration and other related matters;
 2. Recommend programs defined to meet the needs of the professional staff (physicians, pharmacists, nurses, and others) concerning current knowledge on all matters related to drug therapies;
 3. Evaluate clinical and cost data regarding new drugs or agents proposed for use within the medical center and advise/assist in the development of guidelines and monitoring/measurement criteria for appropriate use;
 4. Develop a formulary of drugs accepted for use at the medical center and provide for its continuous revision. The selection of formulary items should be based on objective evaluation of their relative therapeutic merits, safety, and total cost impact on the hospital with an effort to minimize duplication of the same basic medication type. Formulary management strategies will be routinely employed to produce patient care and financial benefits. These strategies include but are not limited to generic equivalents, therapeutic equivalents, therapeutic interchange as well as appropriate use (selection, route, dose, etc.);
 5. Monitor and evaluate adverse drug reactions and medication errors; make appropriate recommendations for system changes to prevent such occurrences;
 6. Maintain procedures for periodic review and approval of prewritten forms that contain medication orders as defined in the medication orders policy. (Pharmacy policy O-1);
 7. Review protocols concerned with the use of investigational or experimental drugs after approval by the Investigation Review Board (can be delegated to P&T committee member serving on IRB);
 8. Provide an ongoing system which will monitor and evaluate appropriateness, safety and optimal clinical effectiveness of selected drugs used in all areas of patient care services and recommend appropriate action, education and follow up to correct problems identified via this program; and
 9. Appoint standing and ad hoc subcommittees. The subcommittees are charged with either permanent or temporary duties and will prepare written reports to the full committee for approval.

SECTION 10. PHYSICIAN PROFESSIONAL PRACTICE COMMITTEE

A. COMPOSITION •

1. There will be seven total members of the committee;
2. Four persons holding appointments to the medical staff who, if practical, will not be serving simultaneously as either chair of a department or officer of the medical staff;
3. Current President Elect and Secretary/Treasurer of the Medical Staff;
4. A psychiatrist or psychologist will be appointed to the PPPC by the chair of the Department of Psychiatry approved by the Medical Staff President and following those steps, ratified by the MEC. The psychiatrist/psychologist is a voting member and may serve for three years;
5. The PPPC may also include, as ex-officio members, such representation from the hospital administration as is recommended by the CEO;
6. All medical staff categories are eligible to serve on the PPPC; and
7. Simple majority of votes will be required for actionable items. A quorum of five members is necessary for actions to be taken.

B. APPOINTMENTS • Each department, except Psychiatry, will be afforded the opportunity to nominate a physician from that department for membership on the PPPC. All nominees must be submitted to the Medical Staff President by November 15th of each year. The Medical Staff President will appoint a new member of the PPPC annually, with confirmation by Medical Executive Committee. Appointments are for a term of four years, and begin in February at the time of the general medical staff meeting.

C. QUALIFICATIONS OF NOMINEES • Nominees to the PPPC in general should be physicians who represent the mission of Saint Alphonsus, the highest levels of professionalism, collaborative respectful relationships with others, and integrity. As such, they should have some experience with the medical staff, having been on the medical staff for at least five years. They must be willing to serve on the committee for four years and assume the chairmanship in the fourth year of their term. They must be willing to undergo any necessary training and ongoing education in the field, and to mentor other physicians new to the committee.

D. CHAIR • The chair will be the member with the greatest number of years of service on the committee. The chair will serve for one year and may serve successive terms thereafter. Since the Department of Psychiatry has a permanent place of membership, the psychiatrist/psychologist will not be eligible to serve as the chair.

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

F. 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 ideally will not interfere.

G. DUTIES •

1. The duties of the PPPC are confined to assisting medical staff leadership (the President and President-elect of the Medical Staff) with the functions of the Impaired Physician Policy and the Disruptive Conduct and the Conduct Policy;
2. Medical staff leadership can make referrals to the PPPC to fulfill the functions of the Impaired

Physician Policy and the Conduct Policy. The PPPC then has the authority to proceed according to those policies with appropriate investigation, recommendations, and action;

3. Consistent with the Conduct Policy, the PPPC can invoke remedial options as outlined in that policy (Section 7 of the Conduct Policy). Such actions include verbal warning, written warning, suspension, training, referral to the corrective action policy, and changes in reappointment. Any recommended action beyond these must be referred to MEC for voting, consideration, and any possible action; and
4. Consistent with the Impaired Physician policy the PPPC will perform any investigations if the Medical Staff President (Section 3, C) institutes an investigation. The role of the PPPC in fulfilling the obligations of the Impaired Physician Policy is contained in that policy.

H. REPORTING • The chair of the PPPC or designee will report to the Medical Staff President and meet with the MEC or Board (when requested by the Board), or their applicable committees upon request, on all recommendations that the committee may make. This will increase direct communication between the MEC and the PPPC on all matters within the scope of the PPPC's duties and to afford the Board the opportunity when requested to communicate directly with the PPPC.

I. MEETINGS AND RECOMMENDATIONS • The PPPC will meet as often as necessary to accomplish its duties, but at least four times a year, and will maintain a permanent record of its proceedings and actions and will report its actions and recommendations to the MEC.

SECTION 11. TRANSFUSION COMMITTEE (Added Section, 2/10)

A. PURPOSE • To review blood and blood product transfusion procedures, utilization, and adverse outcomes in order to assess quality, improve performance and patient safety throughout the organization.

B. COMPOSITION • The Transfusion Committee will be a multidisciplinary committee consisting of medical staff and non-medical staff members:

1. One medical staff member from the following areas:
 - a. General, Vascular & Thoracic Surgery;
 - b. Anesthesiology;
 - c. Medicine;
 - d. Neonatology;
 - e. Oncology;
 - f. Pathology;
 - g. Obstetrics; and
 - h. Emergency Medicine.
2. The following shall serve as Ex Officio members:
 - a. Blood Bank Coordinator; and one representative from the following areas:
 - b. Nursing Services ; and
 - c. Perioperative Services.
3. Other members of both the medical and hospital staff may attend on an Ex-officio basis when requested and approved by the Committee Chair.
4. Chair • The Chair of the Transfusion Committee shall be a physician who is knowledgeable in transfusion medicine.

C. SCOPE • The Transfusion Committee's areas of interest include but are not limited to the following:

1. Ordering practices;
2. Patient identification issues;
3. Sample collection and labeling;
4. Infectious and non-infectious adverse events;
5. Sentinel and near-miss events;
6. Usage and discard;
7. Appropriateness of use;
8. Blood administration policies;
9. The ability of services to meet patient needs;
10. Compliance with peer-review recommendations;
11. Audits for compliance; and
12. Results of Blood Bank inspections by AABB, FDA, CAP, The Joint Commission.

D. DUTIES • The duties and responsibilities of the Transfusion Committee will be:

1. Provide ongoing evaluation of policies and procedures pertaining to blood and blood product transfusion;
2. Establish a mechanism by which data critical to the safe and effective use of blood and blood product is collected and reviewed on an ongoing basis;
3. Review data collected, noting trends and opportunities for improvement;
4. Based on the data collected, make recommendations for improvement;
5. Follow up on implementation of action plans created to address opportunities for improvement identified by the Committee;

E. MEETINGS • The Committee will meet as often as necessary but at least quarterly. The Committee will provide a written report to the Medical Executive Committee annually.

SECTION 12. TRAUMA PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) COMMITTEE

1. COMPOSITION: The Trauma PIPS Committee membership will include:

- a) Trauma Medical Director (TMD)
- b) Hospital Trauma Surgeons
- c) Trauma PAs and NPs
- d) Trauma Program Manager (TPM)
- e) Trauma Coordinator(s) (TC)
- f) Orthopedic Surgeon Liaison (or his/her Designated Alternate)
- g) Emergency Medicine Physician Liaison (or his/her Designated Alternate)
- h) Neurosurgeon Liaison (or his/her Designated Alternate)
- i) Anesthesiologist Liaison (or his/her Designated Alternate)
- j) Radiologist Liaison (or his/her Designated Alternate)
- k) Pre-hospital representative involved with the case
- l) Pediatric Surgeon
- m) Hospital or Health System Administration Representatives as applicable (e.g., Chief Medical Officer (CMO), President, Chief Nursing Officer)
- n) Other Hospital personnel or providers as needed for a thorough review of a specific case or process.

2. CHAIR: The Chair of the PIPS Committee will be the TMD.

3. PURPOSE: The purpose of the PIPS is to monitor, evaluate, and improve the quality of care and reduce morbidity and mortality for Hospital's trauma patients through ongoing data collection, identification of opportunities for improvement, modifications, and communication across disciplines, consistent with the applicable Guidelines of the American College of Surgeons (ACS). The PIPS materials and meeting discussions are intended to be confidential and peer review protected under Idaho Code 39-1392 et. seq., in the same manner as Medical Staff Departmental, and other Hospital peer review committee meetings and discussions.
4. DEFINITIONS: Levels of PIPS Review:
 - a) Primary Review: Conducted by the TPM or TC. Event identification through audit filter flag or concurrent performance improvement (PI) process. Confirm event details, offers immediate feedback/resolution, and determine if further review is required.
 - b) Secondary Review: Conducted by the TPM/TC in conjunction with TMD. Confirm all parties involved, review any additional information, determine if further review is required. May refer to Multidisciplinary Trauma PIPS Committee, Trauma Operations Committee, Specialty Liaisons, or applicable Department Chair.
 - c) Tertiary Review: Structured review by group at PIPS or Trauma Operations. Make determination on efficacy, efficiency, and safety of care. Provide focused education and peer discussion. Determine system versus provider opportunities and contributing factors. Make recommendations for corrective actions. Document loop closure or action items as appropriate.
 - d) Quaternary Review: Provider-specific issues needing further review will be referred to the Department Peer Review Committee and follow Medical Staff processes accordingly. Process issues requiring further review or intervention will be referred to the Medical Executive Committee and/or Hospital Administration as appropriate depending on the nature of the identified issue.
5. DUTIES: The specific duties and functions of the PIPS are:
 - a) Meet monthly or at a cadence that allows for timely review of patients/topics.
 - b) Review all cases identified as requiring Tertiary Review
 - c) All cases will be assigned one of the following scores
 1. Morbidity without opportunity for improvement
 2. Morbidity with opportunity for improvement
 3. Mortality without opportunity for improvement
 4. Mortality with opportunity for improvement
 5. Unanticipated mortality with opportunity for improvement
 - d) All issues will be identified as (may be one or more):
 1. Disease related
 2. Provider related
 3. System related
 - e) Identified issues/events will be scored on the following judgments:
 1. Judgment of Errors – for Provider or System related issues:
 - i. No errors
 - ii. Delay in diagnosis
 - iii. Delay in treatment
 - iv. Error in judgment
 - v. Error in treatment (non-surgical)

- vi. Error in technique (surgical complication)
- vii. Non-compliance with practice guideline
- viii. Poor documentation
- ix. Other

2. Judgment of Impact of Errors:

- i. None: Patient is asymptomatic; no treatment required.
- ii. Minimal: Symptomatic with minimal loss of function/long term consequences; no or minimal treatment required.
- iii. Moderate: Symptomatic requiring intervention (additional surgery or procedure) or increased length of stay or permanent or long-term loss of function.
- iv. Severe: Symptomatic requiring lifesaving intervention/major surgery causing shortened life expectancy or major permanent loss of function.
- v. Death

f) If resolution of issue/event does not take place during this meeting, further actions will be identified. Actions may include:

- i. A letter to the provider
- ii. Referral to Department Peer Review
- iii. Creation of a practice guideline
- iv. Verbal counseling of provider
- v. Education
- vi. Track/trend

g) PIPS minutes will normally be reported to the Medical Executive Committee on a monthly basis

6. Department Peer Review to PIPS Feedback Process:

- a) At times, according to Department peer review criteria, trauma cases may be flagged and evaluated separately from the trauma PIPS.
- b) Trauma cases presented at Department peer review where process or system issues are identified for improvement will normally be communicated to the TPM in person or via confidential and privileged peer review email from the Clinical Excellence/Peer Review Manager to the Trauma PM who will follow up as appropriate with the TMD and PIPS.
- c) Provider-specific care findings of Department peer review are not communicated to the TPM and will be handled through the standard Medical Staff peer review processes.
- d) The TPM is responsible for working with the TMD to validate, track, trend, and address PI-related issues identified and communicated to it following the Department peer review process.

SECTION 13. GRADUATE MEDICAL EDUCATION COUNCIL

A. COMPOSITION • The Graduate Medical Education Council will consist of:

- 1. at least five (5) persons appointed from the active staff;
- 2. the Medical Director of Medical Education will be a member of the active medical staff, a member of the committee and will serve as the chair; and
- 3. the Program Directors or their representatives from each Graduate Medical Education Program;
- 4. the Graduate Medical Education Council may also include, as Ex Officio members, such representatives from the Hospital administration.

B. DUTIES • The Graduate Medical Education Council will:

1. Review activity reports from each Graduate Medical Education program;
2. Make recommendations regarding the supervision, roles, responsibilities and patient care activities for participants of graduate medical education program participants;
3. Acquire from each training program documentation of compliance and accreditation with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation;
4. Work to resolve and residency review committee citations with each education program;
5. Report to the Medical Executive Committee and the Chief Executive Officer and Quality Care and Professional Practices Committee, regarding the safety and quality of patient care, treatment, and services provided, and the related supervisory needs of, the participants in professional education programs; and
6. Maintain a permanent record of its activities.

SECTION 14. INFECTION PREVENTION COMMITTEE

Purpose • The Infection Prevention Committee (IPC) is responsible for the implementation of the Infection Prevention Plan which is designed to prevent and control the spread of infection within the Medical Center and associated outpatient clinics. The committee also oversees infection prevention issues regarding employee health.

COMPOSITION • The Infection Prevention Committee is a multidisciplinary committee composed of:

1. Infection Prevention Officer (IPO), who serves as the committee chair
2. Infectious Disease physicians
3. Infection Prevention Specialists
4. One member of the active Medical Staff representing each of the following specialties:
 - a. General, Vascular and Thoracic Surgery
 - b. Orthopaedics
 - c. Neurosurgery
 - d. Cardiac Surgery
 - e. Obstetrics and Gynecology
 - f. Medicine or Family Practice
 - g. Critical Care/Pulmonary Medicine
5. Representatives from:
 - a. Nursing--Medical/Surgical Unit and Critical Care
 - b. Surgery Department
 - c. Microbiology
 - d. Risk Management
 - e. Patient Safety
 - f. Pharmacy
 - g. Employee Health
 - h. Dietary
 - i. Environmental Services
 - j. Facilities
6. State Epidemiologist
7. Other medical staff and associates

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

MEETINGS • The Infection Prevention Committee will meet at least quarterly and as needed.

AUTHORITY • The Infection Prevention Committee has the authority to institute any appropriate surveillance, prevention and control measures or studies, above and beyond current activities and policies, when there is reason to believe patients or personnel may be in danger of exposure to infectious or communicable disease. This authority ceases when the danger to the patient or personnel is no longer present.

The IPO, Infection Prevention Specialists, and representatives from Pharmacy, Microbiology, and Employee Health form the Infection Prevention Core Group. The Core Group meets weekly or more often as needed to review infection related issues and formulate action plans. The Infection Prevention Core Group has the authority to act on behalf of the Infection Prevention Committee when an action requires expediency. The IP Core Group shall inform the IPC of actions taken as soon as possible. The Infection Prevention Committee reports to the Medical Executive Committee, Boise UCO Ministry Team, and Quality Care and Professional Practice Committee of the Board of Trustees, as needed.

Duties • The Duties of the Committee are to:

1. Oversees the implementation of the Infection Prevention Program.
2. Conducts an annual assessment of the Infection Prevention Program including a review of the goals, objectives, accomplishments and risks. .
3. Monitors the ongoing surveillance program to identify trends of epidemiological significance.
4. Implements organization-wide infection prevention practices based on surveillance data and evidence-based practice.
5. Reviews and approves Infection prevention policies at least every 3 years
6. Provides oversight for associate, provider and patient education related to infection prevention.
7. Assures that communicable and other reportable diseases are reported to the Public Health Department.
8. Identifies infection risks related to employment and institutes appropriate preventive measures in conjunction with Employee Health Services.
9. Provides consultation regarding the purchase of equipment and supplies used for sterilization, disinfection, and decontamination purposes and reviews cleaning procedures, agents, and schedules used throughout the organization. Consults with departments regarding changes in cleaning products or techniques.
10. Reviews deaths occurring in the hospital for possible infection-related sentinel events.
11. Provides oversight for outbreak or cluster investigations, determines possible causes, and takes action as necessary.
12. Serves as a resource to all personnel and departments for Infection Prevention practices.
13. Ensures compliance with all local, state, and federal laws and regulations regarding Infection Prevention.
14. Ensures Infection Prevention participation in the program to monitor the physical building for compliance with safety and cleaning policies

15. Ensures Infection Prevention participation in on all construction projects and performance of an Infection Control Risk Assessment (ICRA).

SECTION 15. UTILIZATION REVIEW COMMITTEE

- A. PURPOSE • To provide for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs as required by the Code of Federal Regulations, 42 CFR 482.30 and Joint Commission's Leadership Standard LD.04.01.01.
- B. COMPOSITION • The Utilization Review Committee will consist of at least two (2) doctors of medicine or osteopathy with representation from the following areas:
1. Clinical Resource Management/Social Work
 2. Other members of both the medical and hospital staff on an ad hoc basis or as requested by the Committee Chair
- C. VACANCIES • Upon notice of medical staff privilege resignation, the President of Medical Staff will appoint a successor to carry out role.
- D. MEETINGS • The committee will meet as often as necessary but at least quarterly.
- E. AUTHORITY • The committee will function collaboratively with medical and hospital staff on matters pertaining to assessment, planning, organizing, directing, and efficiently controlling health care resources in a cost effective manner, while maintaining high quality care.
- F. DUTIES • The Utilization Review Committee will:
1. have oversight of utilization management, denials management, internal and external physician advisor programs, clinical resource management interdisciplinary model, and improvement teams related to utilization management.
 2. establish and maintain a process to evaluate hospital data such as, but not limited to, length of stay, outlier cases, avoidable days, physician advisor and Condition Code 44 cases, and utilization review concerns
 3. work collaboratively with medical and hospital staff on implementation of action plans and tracking outcomes, when appropriate;
 4. be available and work collaboratively with clinical resource managers and attending physicians to make a determination when an admission is not medically necessary for inpatient admission and must be changed to observation; and
 5. review and approve the Utilization Management Plan annually.

CHAPTER VI

OFFICERS OF THE MEDICAL STAFF

SECTION 1. PRESIDENT

A. DUTIES • The President will:

- a. act as the Chief of the Medical Staff, in coordination and cooperation with the Chief Executive Officer in matters of mutual concern involving the Hospital;
- b. call, preside at, be responsible for the agenda of, and keep a report and minutes of Department meetings and of the Medical Executive Committee;
- c. after consultation with the Chief Executive Officer and subject to Board approval, appoint members to all standing, special and multidisciplinary Medical Staff committees except the Medical Executive Committee;
- d. serve as non-voting Ex Officio member of all other Medical Staff and Quality Improvement committees;
- e. represent the views, policies, needs and grievances of the Medical Staff to the Board and to the Chief Executive Officer and communicate all actions and recommendations of the Medical Executive Committee and the Medical Staff to the Board;
- f. 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 Medical Staff's delegated responsibility to provide medical care;
- g. be the spokesman for the Medical Staff in its external professional and public relations; and
- h. report to the Medical Executive Committee, for its consideration, any situation which has come to his or her attention involving questions of clinical competency, patient care and treatment, care management, exclusive service policies or contracts, professional ethics or morals, infraction of hospital or Medical Staff Bylaws or Rules or Regulations or unacceptable conduct on the part of any individual appointed to the Medical Staff. The President has discretionary authority in determining which situations need to be presented.

B. SUCCESSION • When the office of the President is vacated prematurely, the President Elect will assume the office for the remainder of the Medical Staff term. If both Officers are unable to complete their term, a new election will be held.

SECTION 2. PRESIDENT ELECT

A. DUTIES • The President Elect will:

1. assume all duties and have the authority of the President in the event of the President's temporary inability to perform his or her duties;
2. be a member of the Medical Executive Committee of the medical staff and automatically succeed the President when the latter fails to serve for any reason;
3. be a member of the Physician Professional Practice Committee; (Added 4/06)
4. be a member of the Quality and Safety Council and serve as its co-chair; and (rev 2/08)
5. perform such duties as are assigned to him or her by the President.

- B. SUCCESSION • If a vacancy occurs in the President Elect office, a new President Elect will be elected.

SECTION 3. SECRETARY/TREASURER

- A. DUTIES • The Secretary/Treasurer will:
1. act as custodian of staff dues and funds, and make disbursements authorized by the Medical Executive Committee or its designees;
 2. be a member of the Physician Professional Practice Committee; (Added 4/06)
 3. be Chair of the Bylaws Committee; and
 4. serve as parliamentarian at the Medical Executive Committee.
- B. SUCCESSION • If a vacancy occurs in the office of Secretary-Treasurer, the Medical Executive Committee will select a replacement for the remainder of the term. Should the President, President Elect and Secretary/Treasurer be unavailable, the authority and duties of the President will be temporarily assumed by the Chair of the Department of Medicine.

QUALITY AND PATIENT SAFETY COMMITTEE

Section 1. Purpose:

The purpose of the Quality and Patient Safety Council (QPSC) is to manage performance improvement issues and opportunities that involve interdisciplinary practice, practice falling within regulatory scrutiny, and strategic organizational performance. The QPSC identifies opportunities and promotes evidence based best practice standards. The QPSC will define the role and responsibilities for patient safety and provide the framework for a systematic, organization-wide approach to performance measurement, analysis and improvement.

Section 2. Overview:

Saint Alphonsus is committed to providing the highest quality health service and differentiating itself as a recognized leader in defining, measuring, reporting and improving quality of care. The QPSC supports the organization in achieving this commitment and plays a vital role in monitoring and improving patient care to ensure that it is safe, timely, effective, efficient, equitable, and patient centered. Additionally, the QPSC should oversee and be accountable for the organizations' participation in national quality measurement efforts and subsequent quality improvement activities. The QPSC will report to the Quality Care and Professional Practices Committee (QCPPC) of the Board and the SAHS Integrated Quality and Patient Safety Committee. This plan engages active involvement throughout the healthcare team to ensure an environment which:

- Encourages recognition and acknowledgement of risks to patient safety and medical/healthcare errors
- Strives to achieve zero harm
- Initiates actions to reduce risks
- Encourages internal reporting of what has been found and the actions taken
- Focuses on processes and systems
- Encourages organizational learning and supports the sharing of that knowledge to affect behavioral changes in this environment
- Challenges leaders of the organization to be responsible for fostering a safe environment. Leaders within this organization accomplish this through personal example, establishing mechanisms that support effective responses to actual occurrences, reducing medical/healthcare errors through proactive processes, and integrating patient safety priorities into the design of all relevant organization processes, functions and services.

Section 3. Scope of Practice:

1. **Composition:** The Quality and Patient Safety Council will consist of the following members as requested by the Chair and Co-Chair:
 - a. Chief Medical Officer - Chair
 - b. Quality and Patient Safety Manager – Co-Chair
 - c. Chief Nursing Officer
 - d. QCPPC Chair, or Designee(s)
 - e. Vice President of Operations;
 - f. Applicable medical staff/medical directors
 - g. Applicable clinical and operational leaders;

- h. Performance Improvement and Patient Safety Department Representatives;
 - i. Additional participants as requested
- 2. Duties: The Quality and Patient Safety Council will:**
- a. Provide a coordinated approach to improving quality across the organization;
 - b. Provide a forum where the individuals responsible for front line operations may dialogue and express their needs and desires in relationship to the overall strategic goals of the organization;
 - c. Monitor clinical, financial, safety and patient experience indicators;
 - d. Monitor regulatory standards and compliance;
 - e. Create the annual Quality and Patient Safety Plan;
 - f. Commission Functional Teams, Clinical Departments
- 3. Duties: Functional Teams**
- a. Purpose: Functional teams may be utilized and delegated to address specific needs.
 - b. Duties: These teams may modify processes or procedures to increase the output, increase efficiency, or increase the effectiveness of the process or procedure.
 - c. Composition: Functional Teams will be multidisciplinary and membership will be specific to the function/process/practice.
 - d. Creation/Elimination: Functional Teams will be created, eliminated and reconfigured upon recommendation of the Quality and Patient Safety Council. The number and configuration of the Functional Teams is intended to be flexible and easily modified in order to respond to identified opportunities for improvement.
 - e. Reporting: The recommendations, findings and actions of the Functional Teams will be reporting to the Quality and Patient Safety Council
 - f. Examples: Readmissions, Hand Hygiene, Healthcare Associated Infections
- 4. Participants will:**
- a. Participate in the establishment and promotion of safe practices, which help ensure a safe and healthy environment for our patients.
 - b. Foster professional growth and development of self and staff by attending educational activities
 - c. Be prepared to perform work outside of council meetings which may include, but is not limited to:
 - (1) Working with appropriate individuals/departments to correct identified deficiencies
 - (2) Be an advocate with other staff to encourage safe practices
 - (3) Involvement in department performance improvement processes
 - (4) Assist in root cause analysis as necessary
 - (5) Involvement in awareness campaigns and other methods of communication
 - (6) Functional teams will be formed as work groups, to gather consensus as well as address issues on proposed legislation regarding clinical quality, infection control, and patient safety
- 5. Meetings Will:**
- a. The Council will meet no less than six times per year but may increase the frequency of meetings depending on need.
 - b. Ad Hoc meetings will be scheduled by the chair
 - c. Functional Teams will be formed and meet on an as-needed basis.
- 6. Meeting Preparation:**
- a. The committee chair and co-chair will develop objectives, outcomes and an agenda for each meeting.
 - b. Any participant may propose agenda topics at any time.
 - c. The committee will determine timelines for distribution of minutes (key decisions

- and action items), agendas, and associate documents.
- d. Meeting minutes will be distributed within 30 days after each meeting.
 - e. Every effort will be made to distribute the agenda and supporting documents 7 days in advance and to carry out the meeting as planned.

Section 4. Communication and Confidentiality:

Activities of the Quality and Patient Safety Council will be reported to the Medical Executive Committee, Senior Leadership Team, Quality Care and Professional Practices Committee of the Board and the SAHS Integrated Quality and Patient Safety Committee.

All participants will abide by The Confidentiality Responsibilities Policy (which all colleagues sign upon hire).