

MEDICAL STAFF POLICY AND PLANS

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CHAPTER I

ADMISSION

SECTION 1. WHO MAY ADMIT PATIENTS

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

SECTION 2. ADMITTING PHYSICIAN'S RESPONSIBILITIES

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

SECTION 3. ADMITTING CERTIFIED NURSE MIDWIFE RESPONSIBILITIES

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

information concerning the patient as may be necessary to protect the patient or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

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

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

SECTION 5. ALTERNATE COVERAGE

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

SECTION 6. EMERGENCY RESPONSIBILITIES

See Emergency Department Policy and Procedure Manual.

- A. Medical Screening Examinations – All persons who present themselves to the hospital with a request for examination or treatment of a medical condition will receive an appropriate medical screening examination and treatment as required by the federal antidumping laws and regulations and by the Hospital's Policy for Treatment and Transfer of Individuals Who Request Emergency Medical Services (EMTALA). The results of this medical screening examination, and a determination of whether the patient has an emergency medical condition, will be documented in the medical record.
- B. Emergency Admissions - In the case of emergency admissions, patients who do not already have a personal admitting physician will be assigned to a Medical Staff appointee with privileges in the clinical department to which the diagnosis indicates an assignment. Where departmental responsibility is not clear, the ranking available officer of the Medical Staff shall have the ultimate responsibility to determine the appropriate clinical department. The chairman of each clinical department shall provide an assignment schedule for attendance to such patients. Appointees who receive an emergency admission shall, at a minimum, and without regard to

ability to pay, provide all treatment required to stabilize the Emergency Admission patient and shall otherwise comply with the requirements of the federal antidumping laws and regulations.

- C. Call Requirements – The on-call requirements for each physician shall be established for its members by each department and submitted to the Executive Committee for approval. The on-call requirements shall take into consideration the number of specialists and subspecialists in the department and the likelihood of receiving on-call assignments. If there are not a sufficient number of specialists in a particular field to reasonably provide on-call coverage for the emergency room on a full time basis, then the Executive Committee, working with the department and Hospital Administration shall develop alternative methods of providing coverage for the particular specialty.
- D. Emergency Call – Any Medical Staff member who has been scheduled to serve on the Hospital’s Emergency Call Panel (“Panelist”) shall provide “timely consultation” when requested to do so by or at the direction of another Medical Staff member in accordance with the federal antidumping laws and regulations. Courtesy Staff appointees who have agreed to serve on the Hospital’s Emergency Call Panel may not limit their availability while “on call” but must provide “timely consultation” without regard to patient identity, in accordance with the federal antidumping laws and regulations.

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

- E. Mass casualty assignments – All physicians will be called to the Hospital by assigned personnel. Physicians report to the Control Center for assignment to the areas where assistance is needed. The signing-in process establishes the priority for staffing by physicians. The Chairman of the Emergency Department or the Emergency Physician on duty at the time of the disaster is in charge of the triage. In the event evacuation of patients is required from the Hospital premises, dismissal will be authorized by the physician assigned to the department. All physicians on the Staff specifically agree to relinquish direction of the professional care of their patients to the physician assigned to each area during a disaster.
- F. Use of Registered Nurses to Perform Medical Screening Examinations Under the Federal Anti-Dumping Laws and Regulations for Conditions Related to Pregnancy and Labor - Registered Nurses of the Obstetrics Department are determined, pursuant to federal law, to be qualified to provide Medical Screening Examinations to pregnant women having contractions to determine whether they are in active labor or whether they have a urinary tract infection, and to assess fetal

well-being. The Registered Nurses are determined to be qualified with proof of current competency.

- G. Use of Mid-Level Practitioners to perform Medical Screening Examinations Under the Federal Anti-Dumping Laws and Regulations – Nurse Practitioners and Physicians Assistants are determined, pursuant to federal law, to provide Medical Screening Examinations to persons who present themselves to the hospital with a request for examination or treatment. Nurse Practitioners, and/or Physicians Assistants are determined to be qualified in accordance with their applicable approved privileges.
- H. Use of Registered Nurses, Nurse Practitioners, and Physicians Assistants to Certify Transfers under the Federal Anti-Dumping Laws and Regulations - Registered Nurses, Nurse Practitioners, and Physicians Assistants are authorized, pursuant to federal law, to sign a certification for transfer to another facility in consultation with the physician.
- I. Treatment of Patients in the Emergency Department by Non-Emergency Department Physicians - Members of the Medical Staff who are not under contract to provide emergency medicine services in the Emergency Department may meet their patients, for the purpose of providing medical treatment, in the Emergency Department, subject to the following conditions and requirements:
 - 1. Subject to subsection (e) above, all patients who present to the Emergency Department will be triaged and will receive a Medical Screening Examination by an Emergency Department Physician, Nurse Practitioner, or Physicians Assistants unless their personal physician is physically present in the Emergency Department. In that case, the personal physician may conduct the Medical Screening Examination provided he/she has privileges at the Hospital to do so. All such examinations shall be conducted in accordance with the Hospital and Emergency Department policies, protocols and procedures and the federal anti-dumping laws and regulations. The results of the Medical Screening Examination and a determination whether the patient has an emergency medical condition, will be documented in the medical record by the examiner.
 - 2. Any member of the Medical Staff who is not under contract to provide emergency medicine services in the Emergency Department who provides a Medical Screening Examination as set forth in (1) above shall provide such examination, and any subsequent stabilization and/or treatment in accordance with the Hospital's Policy for Treatment and Transfer of Individuals Who Request Emergency Medical Services (EMTALA).

SECTION 7. PRE-ADMISSION LABORATORY TESTS

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

SECTION 8. CONTINUED HOSPITALIZATION

The attending physician is required to routinely document the need for continued hospitalization

after specific periods of stay. This statement must contain:

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

CHAPTER II

MEDICAL ORDERS

SECTION 1. POLICY ON ORDERS

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

- Radiation Physicist
- c. When a verbal/telephone order is taken, it must be documented and read back to the authorized person giving the order to confirm. The order should contain a statement that the order was confirmed after being read back. For Example:
- For paper based medical records:
 - VORB (Verbal Order Read Back), followed by the signature of the person taking the order.
 - For electronic medical records:
 - Select appropriate communication order type (e.g. 'verbal order' or 'phone order')
 - These orders are routed to the provider for electronic signature

SECTION 2. MEDICATION ORDERS

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

CHAPTER III

CONSULTATIONS

SECTION 1. WHO MAY GIVE CONSULTATIONS

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

SECTION 2. REQUIRED CONSULTATIONS

- A. Consultations are required in all cases in which, in the judgment of the attending physician:
1. the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 2. there is doubt as to the best therapeutic measures to be used; or
 3. unusually complicated situations are present that may require specific skills of other physicians.
- B. Authorized APPs must obtain consultations as prescribed in their privilege form
- C. It shall be the responsibility of all individuals exercising clinical privileges to obtain any required consultations. Requests for urgent consultations shall be verbally communicated by the requesting practitioner to the consulting practitioner. All other requests for consultations may be made by written order. All requests for a consultation shall be entered in the medical record together with an explanation of the clinical basis for the requested consultation.
- D. If the history and physical are not on the chart, it shall be the responsibility of the physician or authorized APP requesting the consultation to document and provide this information to the consultant.
- E. If after discussion with the attending physician or authorized APP, a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse may call this to the attention of his/her superior, who, in turn, may refer the matter to the Vice-President of Patient Care Services, or designee. The Vice-President of Patient Care Services, or designee, may bring the matter to the attention of the chairman of the department in which the physician or authorized APP in question has clinical privileges and the Vice-President of Medical Affairs, and shall notify the attending physician or authorized APP of this action. In all situations that require it, the chairman of the department may request a consultation after appropriate discussion with the attending physician or authorized APP.

SECTION 3. CONTENTS OF CONSULTATION REPORT

Each consultation report should contain a written opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record. A limited statement, such as "I

concur" does not constitute an acceptable consultation report. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record. The consultation report shall contain the date of the consultation and the signature of the consultant.

SECTION 4. SURGICAL CONSULTATIONS

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

CHAPTER IV

SURGICAL CARE

SECTION 1. SCHEDULING SURGERY/PROCEDURES

See OR Scheduling Policy

SECTION 2. CONSENT

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

SECTION 3. PERFORMING SURGERY ON FAMILY MEMBERS

Surgeons are discouraged from performing surgery on family members.

SECTION 4. ANESTHESIA

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

record.

H. Anesthesiologists are discouraged from administering anesthetics to family members.

SECTION 5. PACU ADMISSION AND DISCHARGE REQUIREMENTS

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

SECTION 6. ADMISSION RESPONSIBILITIES FOR DENTAL OR PODIATRIC PATIENTS

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

A. Dentists' and Podiatrists' responsibilities:

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

B. Physicians' responsibilities:

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

SECTION 7. SURGICAL PRIVILEGES

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

SECTION 8. PATHOLOGY REPORT

Ordinarily, tissues or exudates removed during a surgical procedure shall be labeled and sent to the Laboratory for examination by the pathologist. The extent of the examination shall be determined by the pathologist, based on pertinent clinical information, including the source and the preoperative and postoperative diagnosis. The pathologist shall sign his report, which becomes

part of the patient's medical record.

Certain categories of specimens may, at the surgeon's discretion, be discarded, with documentation of same in the patient's medical record by the surgeon.

These specimens include:

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

SECTION 9. OBSTETRICAL AND GYNECOLOGICAL SURGERY

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

CHAPTER V

NURSERY AND CARE OF NEWBORN

See Pediatrics Policies and Procedures.

SECTION 1. EXAMINATIONS

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

SECTION 2. HIGH-RISK INFANTS

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

SECTION 3. PROPHYLACTIC TREATMENT OF NEWBORNS

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

SECTION 4. CONSULTATIONS

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

CHAPTER VI

MEDICAL RECORDS

SECTION 1. GENERAL RULES

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

SECTION 2. AUTHENTICATION

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

SECTION 3. TRAINING IN THE ELECTRONIC HEALTH RECORD

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

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

SECTION 4. CONTENT

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

- A. The patient's name, sex, address, date of birth, and authorized representative, if any;
- B. Legal status of patients receiving behavioral health care services;
- C. Documentation and findings of assessments;
- D. Conclusions or impressions drawn from medical history and physical examination;
- E. The diagnosis, diagnostic impression or conditions;
- F. The reason(s) for admission or care, treatment and services;
- G. The goals of the treatment and treatment plan;
- H. Evidence of known advance directives;

- I. Evidence of informed consent when required by hospital policy;
- J. Diagnostic and therapeutic orders;
- K. All diagnostic and therapeutic procedures, tests and results;
- L. Operative or other invasive procedures;
- M. Progress notes made by authorized individuals;
- N. All reassessments and plan of care revisions, when indicated;
- O. Relevant observations;
- P. The response to care, treatment and services provided;
- Q. Consultation reports;
- R. Allergies to foods and medicines;
- S. Every medication ordered or prescribed;
- T. Every dose of medication administered (including the strength, dose or rate of administration, administration devices used, access site or route, known drug allergies and any adverse drug reaction);
- U. Every medication dispensed or prescribed on discharge;
- V. All relevant diagnoses/conditions established during the course of care, treatment and services;
- W. Records of communication with the patient regarding care, treatment and services, for example, telephone calls or e-mail, if applicable;
- X. Patient-generated information (for example, information entered into the record over the web or in pre-visit computer systems), if applicable;
- Y. Clinical resumes and discharge summaries, or a final progress note or transfer summary;
- Z. Emergency care, treatment and services provided to the patient before his or her arrival, if any; and/or
- AA. For emergency room records, time and means of arrival and condition on discharge.

SECTION 5. REQUIREMENTS FOR COMPLETING AND DOCUMENTING MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS

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

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

If, upon examination, the practitioner finds no change in the patient's condition since the H&P was completed, the practitioner may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's

condition since the H&P was completed.

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

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

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

History and Physical Scope of Assessment - The history and physical must include the elements, based on service, indicated on the following table:

MEDICAL HISTORIES AND PHYSICAL EXAMS

Required Elements:	Inpatients	Outpatients		
		Receiving General Anesthesia	Receiving Spinal , Epidural Anesthesia and Regional Block (Including Sedation)	Receiving topical, local or no sedation and pain control injections
Chief Complaint/Provisional/Pre-op Diagnosis	X	X	X	X
Details of Present Illness	X	X	X	
Allergies	X	X	X	
Current Medications	X	X	X	
Medical and Surgical History	X	X	Relevant to Procedure	
Social and Family History Appropriate to Patient’s Age	X	X	Relevant to Procedure	
Inventory of Body Systems	X	X	Relevant to Procedure	
Complete Physical Examination	X	X	Relevant to procedure (must include cardiopulmonary exam)	Specific to the procedure to be performed
Conclusions or Impressions	X	X	X	
Plan of Care	X	X	X	

SECTION 6. PROGRESS NOTES

- A. Progress notes shall be entered in the medical record by the attending physician or authorized APP, as well as by every other practitioner who examines the patient. Progress notes should give a pertinent chronological report of the patient's course in

the Hospital and reflect any change in condition and the results of treatment. Progress notes shall be legible, recorded, timed and dated at the time of observation and shall contain sufficient content to insure continuity of care if the patient is transferred.

Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Individuals who have been granted clinical privileges and specified professional personnel may also write pertinent progress notes

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

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

SECTION 7. OPERATIVE AND HIGH-RISK PROCEDURE NOTES AND REPORTS

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

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

SECTION 8. DISCHARGE SUMMARY/FINAL PROGRESS NOTE

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

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

1. The reason for hospitalization;
2. Significant findings;
3. Procedures performed and care, treatment and services provided;
4. The patient's condition at discharge; and

5. Instructions to the patient and family.

- B. For patients that are hospitalized less than forty-eight (48) hours, and for newborns with uncomplicated deliveries, a discharge summary or discharge progress note will be legibly written or dictated documenting the primary discharge diagnosis, any operative procedures, the patient's condition at discharge, discharge instructions and follow-up care required.
- C. Timeliness – It is preferred that the discharge summary is dictated, signed, dated and timed within seven (7) days of discharge. The discharge summary will be considered delinquent if not dictated and signed, dated and timed within thirty(30) days of discharge.
- D. A discharge summary completed by an authorized APP will be counter-signed by their collaborating or sponsoring physician, or their designee.

SECTION 9. FAILURE TO COMPLETE MEDICAL RECORDS

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

A. Timeliness of Documentation

1. History and Physical:

New admissions will be monitored daily for presence of a history and physical;

- a. If a history and physical is not dictated, received from the physician's or authorized APP's office or legibly hand-written in the record within twenty-four (24) hours of admission the responsible physician or authorized APP is placed on the Blue Tag list and provided a warning;
- b. If the history and physical is not dictated, received from the physician's or authorized APP's office or legibly hand-written in the record within forty-eight (48) hours of admission the responsible physician or authorized APP is placed on the Red Tag list;

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

2. Operative Report:

Surgical records will be monitored daily for the presence of an operative report.

- a. If an operative report is not on the chart within twenty-four (24) hours of a surgical procedure, the responsible physician will be placed on the Blue Tag list and provided warning;
- b. If the operative report is not dictated within one (1) week of being placed on the

Blue Tag list, the physician will be placed on the Red Tag list.

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

3. Discharge Summary:
 - a. If the discharge summary is not dictated and signed or authenticated within seven (7) days of discharge, the responsible physician or authorized APP will be notified in writing;
 - b. If not dictated and signed or authenticated within fourteen (14) days of discharge, the physician or authorized APP will receive a second written notice;
 - c. If the discharge summary is not dictated and signed or authenticated within twenty- one (21) days of discharge, the responsible physician or authorized APP will be notified in writing and phoned at his or her office and placed on the Blue Tag list;
 - d. If the physician or authorized APP does not dictate and sign or authenticate the discharge summary within thirty (30) days of discharge the physician or authorized APP will be placed on the Red Tag list.

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

B. Notification of Untimeliness:

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

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

delinquent records are completed. Any physician and/or authorized APP on the Red Tag list for thirty (30) consecutive days shall be administratively suspended until all records are completed.

C. Extension:

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

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

D. Methods of Notification:

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

E. Disciplinary Action:

Any physician or authorized APP who has been on the Red Tag list four (4) times during the preceding 365 days shall be reported to the Chief Executive Officer, the President of the Medical Staff and Medical Executive Committee. If the physician or authorized APP is placed on the Red Tag list two (2) additional times during the subsequent 365 days, he/she shall automatically be placed on probation for 365 days.

During any such probationary period, if the physician or authorized APP is on the Red Tag list two (2) additional times, the physician's or authorized APP's membership shall be automatically relinquished and the physician or authorized APP shall be required to reapply for membership on the Medical Staff or APP staff.

F. Definitions:

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

SECTION 10. POSSESSION, ACCESS AND RELEASE

See Medical Records Policies and Procedures.

- A. All medical records are the physical property of the Hospital and shall not be taken from

- the confines of the Hospital. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.
- B. All access to patient records will comply with HIPAA Confidentiality and Security Policies.
 - C. Access to the medical records of all patients shall be afforded to appointees of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Former Staff appointees or APPs shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital. Any publication of compiled data from the Hospital's patients' medical records is forbidden without written approval of the Chief Executive Officer.
 - D. Written consent of the patient is required for release of medical information to those not otherwise authorized by HIPAA policies to receive this information.

CHAPTER VII

INFORMED CONSENT

It is the policy of Saint Alphonsus Medical Center-Nampa that a patient or patient representative gives voluntary and informed consent for all care, treatment and services involving material risk.

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

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

CHAPTER VIII

DISCHARGE

SECTION 1. WHO MAY DISCHARGE

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

SECTION 2. TRANSFER OF PATIENTS

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

SECTION 3. DISCHARGE OF MINORS AND INCOMPETENT PATIENTS

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

SECTION 4. DEATH, AUTOPSIES AND CORONER'S CASES

- A. In addition to physicians, RN's may make a determination that death has occurred, as defined in the Pronouncement of Death Nursing Procedure. This information may be relayed by the RN to the physician by telephone, whereupon the physician has the prerogative to conclude that the person is dead.
- B. The hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the medical staff (specifically the attending physician or clinical psychologist) of autopsies that the hospital intends to perform.
- C. An autopsy may be performed only with proper consent in accordance with state law and Hospital policy. All autopsies shall be performed by the Hospital pathologist or by his designee. Provisional anatomic diagnoses shall be recorded on the medical record within forty-eight (48) hours of completion of the autopsy and the complete protocol shall be made a part of the medical record within thirty (30) days.
- D. The Pathologist, or designee, will notify all attending and consulting physicians of the date and time that the hospital-based autopsy or non-coroner autopsies will be performed.
- E. As defined in the Hospital's Organ and Tissue Donation Procurement Policy, physicians will work in cooperation with the Hospital to refer all deaths to donor agencies to determine medical suitability of organs and tissues available for transplant.

- F. It is the responsibility of the attending physician, or his alternate, to notify the coroner of any cases considered a coroner's case. The following are classified as coroner's cases in Canyon County:
1. cases of death as a result of violence, whether apparently homicidal, suicidal or accidental;
 2. cases of death under suspicious or unknown circumstances; and
 3. unattended deaths.

CHAPTER IX

CRITERIA FOR CLINICAL PRIVILEGES

SECTION 1. CRITERIA FOR CLINICAL PRIVILEGES

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

SECTION 2. AVAILABILITY OF CURRENT CRITERIA FOR CLINICAL PRIVILEGES

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

SECTION 3. MEDICAL STAFF NEW PRIVILEGES POLICY AND PROCEDURE

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

A new procedure is defined as any procedure that:

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

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

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

C. PROCEDURE/GUIDELINES:

New Procedure/Services:

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

1. Practitioner shall request privileges for the new procedure, new service, or extension of current privileges, in writing, on a form provided by the Hospital. The request shall include the following:
 - a. Name of the procedure or service
 - b. Technique of procedure or service
 - c. Similarities to and differences from existing procedures or services
 - d. What, if any, new or additional equipment is required
 - e. A list of training programs attended
 - f. Specialty/Subspecialty involved
 - g. Standards for granting such privilege(s) from specialty society/board/academy
2. Request shall be forwarded to the next scheduled Credentials Committee, including the documentation and information provided by the Practitioner, as noted in item A1 above.
3. Credentials Committee shall review the request and accompanying documentation and shall determine that the request is an extension of current privileges, or that it is not an extension of current privileges and that criteria need to be developed.
 - a. If the request is determined to be an extension of current privileges, no further action is necessary and the practitioner shall be so notified.
 - b. If the request is determined NOT to be an extension of current privileges, the Credentials Committee may appoint an ad-hoc committee or refer the issue to an existing Medical Staff Department or Committee for the development of criteria, and the practitioner shall be so notified.
4. When more than one specialty or subspecialty is involved in performing the requested procedure, Credentials Committee will appoint an ad-hoc committee with at least one (1) representative from each specialty/subspecialty involved.
5. The ad-hoc committee or Medical Staff Department will review the request taking into consideration the following:
 - a. Current competence and clinical judgment
 - b. Professional ethics
 - c. Education, training and experience
 - d. Participation in continuing education
 - e. Use of Hospital facilities
 - f. Compliance with Medical Staff Bylaws, and Policy and Plans;
6. The ad-hoc committee or Medical Staff Department shall develop criteria to determine those who are competent to exercise the clinical privilege(s) or decide that no criteria are necessary.

The following guidelines shall be used in development of privileging criteria. (The purpose of these guidelines is to define the training, competence and experience required to perform the requested clinical privilege(s):

- a. The type of basic education (degree) required to apply for the privilege(s)
 - b. Board certification requirements, if any
 - c. Formal post-graduate training requirements (i.e. residency, fellowship, etc.).
 - 1) All post-graduate training must take place in a program approved by either the American Medical Association (AMA), American Osteopathic Association (AOA), American Podiatric Medical Association (APMA), or Accreditation Council for Graduate Medical Education (ACGME).
 - 2) In the case of new procedures, the training required outside of post-graduate programs.
 - d. The amount of recent practice experience required (within the last 12-24 months).
 - 1) All practice experience must be sponsored by a training program or hospital facility with a formal quality or peer review program.
 - e. Whether any continued didactic or hands-on training is required.
 - f. Number and types of references necessary to evaluate skills, judgment and current clinical competence.
 - g. Proctoring or monitoring requirements.
 - h. Requirements to maintain privileges (i.e. number of procedures, CME, etc.) to be provided at time of reappointment.
 - i. Indications and contraindications
 - 1) The ad-hoc committee or Medical Staff Department has sixty (60) days to make a report/recommendation to the Credentials Committee.
7. Credentials Committee shall review the report and/or recommended criteria from the ad-hoc committee or Medical Staff Department and make a written recommendation (including the rationale for the recommendation) to the Medical Executive Committee.
8. Medical Executive Committee shall review the written recommendation and/or recommended criteria of Credentials Committee and make a written recommendation to the Board.
9. The Board shall review the written recommendation and/or recommended criteria of Medical Executive Committee and make a final decision, taking into consideration the following factors:
- a. The community and patient need³
 - b. The capacity of the Hospital to support the new procedure or service requested, including whether appropriate equipment, space, supplies, trained staff, scheduling and other necessary resources are available.
 - c. Quality of care issues
 - d. Patient convenience
 - e. Reimbursement issues
 - f. Any other business or patient care objectives of the Hospital which the Board believes are relevant to the disposition of the request.

10. The Board reviews the information and documentation provided by the practitioner and either determines to allow the procedure or service to be performed or determines that the procedure or service shall not be performed at Saint Alphonsus Medical Center – Nampa, Inc.
11. If the Board’s determination is to allow the procedure or service to be performed, the new privileges will be added to the privilege form, along with the recommended criteria, and the practitioner may apply for the privilege(s).
12. If the Board’s determination is not to allow the procedure or service to be performed at the Hospital, the practitioner shall be so notified.

**Addendum 1
CLINICAL PRIVILEGE CRITERIA
GUIDELINES**

General Criteria	Description of Criteria	Required Qualification(s) For Clinical Privilege(s)
Basic Education (MD, DO)	Degree required to perform the requested privilege(s)	
Board Certification	Specify the Board certification requirements for the requested privilege(s)	
Formal Training	Specify the type and extent of formal training, such as type of residency, fellowship or other training	
Experience	How much practice experience (within the past 12-24 months) the practitioner must demonstrate	
Continued Training	Continued training requirements and/or didactic or hands-on experience required to maintain privilege(s) if any	
Number and types of references	Specify the number and types of references required to evaluate training, ability, judgment and current clinical competence	
Special Proctoring or Monitoring	Specify any special proctoring or monitoring requirements	
Maintaining Privileges	Specify requirements to maintain privileges (i.e. number of procedures, CME, etc.)	
Indications/Contraindications	Specify Indications/Contraindications of procedure	

SECTION 4. POLICY FOR CREDENTIALING/PRIVEGING VOLUNTEER LICENSED INDEPENDENT PRACTITIONER(S) IN THE EVENT OF DISASTER

A. Purpose:

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

B. Policy:

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

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

C. Procedure:

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

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

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

1. The practitioner credentialed in a disaster situation shall complete the "Temporary Disaster Privilege Form" (attached) which includes a statement attesting that the information given to the hospital is accurate.
2. The practitioner agrees to be bound by all hospital bylaws, policies and rules, Medical Staff Bylaws Rules and Regulations, and policies, and directives from the department chair, supervising/collaborating physician, or any other hospital or medical staff leader.
3. Volunteers considered to be eligible to act as licensed independent practitioners in the organization must at a minimum present:
 - a. A valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport)
 - b. A list of current hospital/surgery center affiliations(s) where the practitioner currently holds privileges.
AND
 - c. AT LEAST ONE OF THE FOLLOWING (copied and verified when possible):
 - 1) A current picture hospital ID card that clearly identifies professional designation
 - 2) A valid current license to practice
 - 3) Primary source verification of the license
 - 4) Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-

- VHP), or other recognized state or federal organization or group
- 5) Identification indicating that the practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances by a federal, state, or municipal entity
 - 6) Identification by current hospital or medical staff member(s) who possess personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster
4. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following:
 - a. Why primary source verification could not be performed in the required time frame;
 - b. Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services; and
 - c. Evidence of attempt to perform primary source verification as soon as possible. Primary source verification of license would NOT be required if the volunteer practitioner has not provided, care, treatment and service under the disaster privileges policy.
 5. The Medical Staff Office will also query the NPDB and the OIG.
 6. Any information gathered that is not consistent with that provided by the practitioner will be referred to the Chief Executive Officer or the Medical Staff President (or their designees) who will determine appropriate action.

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

7. Once the practitioner obtains approval for disaster privileges, a temporary identification card will be issued. The identification card will state the practitioner's name, specialty and assignment.
8. The medical staff oversees the professional practice of volunteer licensed independent practitioners during a disaster. When feasible, the practitioner will practice under the direction and supervision of a credentialed member of the Medical Staff. The organization will conduct a random review of the volunteer licensed independent practitioner's clinical work following the disaster. Review could include direct observation, mentoring or clinical record review.
9. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer licensed independent practitioner) within 72 hours related to the continuation of the disaster privileges initially granted.

10. Disaster privileges are valid ONLY for the duration of the disaster and will automatically terminate at the end of the need for the practitioner's services.



MEDICAL STAFF OFFICE
Phone (208)205-2046
Fax (208)205-2049
E-Mail: Kristine.Wimer@saintalphonsus.org

TEMPORARY DISASTER PRIVILEGES FORM

Date of Disaster: _____

BADGE # _____

I. INFORMATION

Practitioner Name _____

Specialty.....

Address.....

City, State, Zip Code.....

Telephone Number..... Social Security #.....

Date of Birth..... Birthplace..... Sex.....

Name of Professional Liability Insurance Coverage Company.....

Hospital(s)/Surgery Centers where Practitioner holds current privileges

.....

.....

I certify that the above information is true and correct to the best of my knowledge, information and belief.

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

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

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

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

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

Signature of Practitioner

Date

Practitioner Name – Please Print

II. IDENTIFICATION(S) – Photocopy when possible:

- 1. Valid government-issued photo identification issued by a state or federal agency:
 - a. Driver's License
 - b. Passport
 - c. Other – mustspecify: _____

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

Verifications Completed By (Name On Line Above) _____

Date _____

III. LICENSE PRIMARY SOURCE VERIFICATION – To be completed immediately or within 72 hours:

<p>License: _____</p> <p>Idaho MD/DO/PA: http://www.bom.state.id.us</p> <p>Telephone: 208/327-7000</p> <p>Fax: 208/327-7005</p> <p>Idaho NP/CNM: http://www2.idaho.gov/ibn</p> <p>Telephone: 208/334-3110</p> <p>Fax: 208/334-3262</p>	<p>Date Verified:</p>	<p>Verified By:</p>	<p>Primary Source Verification cannot be completed within 72 hours due to the following extraordinary circumstances:</p>
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IV. PRIMARY SOURCE VERIFICATIONS – OTHER THAN LICENSE – To be completed within 72 hours:

Hospital Verification:	Verification By:	Verified By: (Name)	Primary Source Verification Cannot be completed within 72 hours due to the following extraordinary circumstance:
<p>Name:</p> <p>Name:</p> <p>Name:</p>	<p><input type="checkbox"/> Telephone <input type="checkbox"/> Fax</p> <p><input type="checkbox"/> Telephone <input type="checkbox"/> Fax</p> <p><input type="checkbox"/> Telephone <input type="checkbox"/> Fax</p>		
<p>NPDB Query: https://www.npdb-hipdb.hrsa.gov</p>	<p><input type="checkbox"/> Website</p>		
<p>OIG Check: http://exclusions.oig.hhs.gov/search</p>	<p><input type="checkbox"/> Website</p>		
<p>Idaho Excluded Provider Check: http://www.healthandwelfare.idaho.gov</p>	<p><input type="checkbox"/> Website</p>		
<p>Professional Liability Insurance Coverage</p>			

V. APPROVALS

Chief Executive Officer OR Medical Staff President (or designee):	
_____	_____
Signature of Approval – Chief Executive Officer (or designee)	Date and Time
OR	
_____	_____
Signature of Approval – President of Medical Staff (or designee)	Date and Time


VI. FOLLOWUP:

TEMPORARY IDBADGE# _____
Medical Staff/MLP Collaborating/Supervising Practitioner: _____

VII. 72 HOUR DETERMINATION:

72 Hour Due Date and Time: _____
<input type="checkbox"/> Continuation
Of disaster privileges is authorized as determined by the Hospital's Emergency Management Plan.
<input type="checkbox"/> Situation no longer exists
<input type="checkbox"/> Credentialing revealed adverse information

SAMPLE ID BADGE:

 Saint Alphonse Medical Center NAMPA	TEMPORARY ID BADGE # _____ PRACTITIONER WITH DISASTER PRIVILEGES
Name:	
Specialty:	
SAMC-N Supervisor:	
Assignment/Area:	
Date Assigned:	

SECTION 5. TELEMEDICINE POLICY

A. Policy

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

B. Purpose

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

C. Responsibility

Personnel in the Medical Staff Office of Saint Alphonse Medical Center - Nampa, Inc.

D. Definitions

Telemedicine: Telemedicine is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.

Originating Site: Originating Site is the site at which the patient is located or where the equipment is located.

Distant site: Distant Site is the site from which the prescribing or treating services are provided.

E. Privileges and Credentialing

1. Telemedicine Services for LIP's Responsible for Care, Treatment and Services Licensed Independent Practitioners (LIPs) who have either total or shared responsibility for patient care, treatment and services through a telemedicine mechanism must be credentialed and privileged, utilizing one of the following mechanisms:

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

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

2. LIP's Who Provide Interpretive Services

LIPs providing interpretive services such as official readings of images, tracings

OR

specimens (e.g. radiologists or pathologists) must do so under one of the following two arrangements:

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

- a. The LIP is fully credentialed and privileged at this facility; or
- b. The LIP is privileged at this facility using credentialing information from the Distant Site if the requirements in section E.3., below are met.

OR

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

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

- a. The Distant Site must be TJC accredited;
- b. The LIP must be privileged at the Distant Site for the services to be provided at the Originating Site; and
- c. The Originating Site has evidence of an internal review of the LIP's performance of these privileges and sends to the Distant Site, information that is useful to assess the LIP's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events, considered reviewable by the TJC that result from the telemedicine services provided and complaints about the Distant Site LIP from patients, other LIPs, or staff at the Originating Site.

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

- a. The Medical Executive Committee (MEC) has recommended that the scope of telemedicine services provided at this (Originating/Distant Site) hospital and the (Distant Site/Originating Site) hospital include the privileges requested by the LIP. Both the Originating Site MEC and the Distant Site MEC must approve this scope of services.
- b. The LIP must concurrently maintain privileges, at a minimum, for the same scope of services at the Distant Site as he or she is requesting at the Originating Site.

5. Requests for telemedicine privileges at the Originating Site will be processed through the established procedure for reviewing and granting privileges at the Originating Site. Information included in the completed LIP application for telemedicine privileges at the Originating Site may be collected in the usual manner or may be collected from the Distant Site.
6. LIPs applying to the Saint Alphonsus Medical Center - Nampa, Inc. Staff for the purpose of providing telemedicine services at this facility, will be required to comply with the Medical Staff Bylaws with the exception of the following:
 - a. Article II – Divisions of Medical Staff/Call Coverage
 - b. Article III – Part D – Department Meeting Attendance Requirements
 - c. Article IV—Part A: Qualifications for Appointment and Continued Membership:
 - i. Section 2 (c) Are located close enough to provide timely care for their patients
 - ii. Section 4 (c) An agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him by the hospital.
 - iii. Section 4 (o) A pledge to provide continuous care for patients in the hospital.
 - iv. Section 4 (p) A pledge to participate in the monitoring and evaluation of activities of clinical departments
 - v. Section 4 (s) A pledge to pay promptly any applicable Medical Staff dues and assessments.
 - d. Article V—Part A: Procedure for Reappointment:
 - i. Section 3 (c) Attendance at Medical Staff meetings and participation in staff duties as defined by their staff category.

F. Scope of Services

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

G. Peer Review and Quality Data

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

H. Termination

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

SECTION 6. EXPEDITED CREDENTIALING POLICY

A. PURPOSE: To provide a more efficient mechanism for review of requests for new or

renewed medical staff and Advanced Practice Professional applications for membership and privileges without compromising quality of review. “Expedited” credentialing provides an expedited review and approval process if specific, pre-defined, Board approved criteria are met.

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

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

1. Category One - Expedited:

Category One applications must meet all of the following criteria:

- a. All requested information has been returned promptly;
- b. The application does not contain inaccurate or incomplete information;
- c. The application does not contain unexplained gaps in time;
- d. There are no discrepancies in information received from the applicant or references;
- e. There are no negative or questionable references;
- f. The applicant has completed a normal education/training sequence;
- g. The applicant has an unremarkable medical staff/employment history;
- h. The applicant has submitted a reasonable request for clinical privileges consistent with his/her specialty, and based on experience, training, and competence, and is in compliance with applicable criteria;
- i. Medical staff membership, staff status and/or clinical privileges have never been resigned, denied, revoked, suspended, restricted, reduced, voluntarily or involuntarily surrendered, or not renewed at any other health care facility;
- j. The applicant has never withdrawn application for appointment, reappointment or clinical privileges or resigned from the medical staff before a decision was made by another health care facility's governing board;
- k. The applicant possesses current, valid Idaho license, professional liability insurance (in limits approved by the hospital and with no excluded areas of coverage), and federal and/or state narcotics certificate(s), if applicable;
- l. No license(s), DEA or other controlled substance authorizations, or membership in local, state or national professional societies have ever been suspended, modified, terminated or voluntarily or involuntarily surrendered or are pending;
- m. Specialty board certification or eligibility has never been denied, revoked, relinquished, not renewed, suspended or reduced, nor have proceedings toward those ends been instituted;
- n. The applicant has never been named as a defendant in a criminal action and/or has never been convicted of a crime;
- o. There are no National Practitioner Data Bank entries other than a malpractice history which meets the requirements of subsection p below;

- p. The Applicant has not been involved in three (3) or more malpractice claims in the past ten (10) years or any settlements or judgements in the past five (5) years;
 - q. There are no proposed or actual exclusions and/or any pending investigations of the applicant from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid;
 - r. The applicant has indicated that he/she can safely and competently exercise the clinical privileges requested, with or without a reasonable accommodation;
 - s. The applicant's history shows an ability to relate to others in a harmonious, collegial manner;
 - t. There is no final recommendation by Medical Executive Committee that is adverse or has limitations;
 - u. At the time of renewal of privileges, documentation of activity in the hospital and/or verification from outside healthcare entities and/or peers sufficiently verifies current competence;
 - v. At the time of renewal of privileges, there is no adverse information reported on the reappointment profile.
2. Processing Category One Applications:
- a. The Medical Staff Office receives and processes the application.
 - b. The appropriate department chair and the Credentials Committee Chair, or designees, review the completed and verified application.
 - c. The Department and Credentials Committee Chair, or designees, forward a report with findings and a recommendation to the Medical Executive Committee, which reviews the application at its next scheduled meeting.
 - d. The Chief of Staff then forwards the Executive Committee's recommendation to the Governing Board, which reviews the application at its next scheduled Board meeting.
 - e. If, at any point, any reviewer feels the application does not meet Category One criteria, the file will be considered Category Two and the usual review process (Category Two) will be followed.
 - f. An informational report will be made to all members of Credentials Committee at its next regularly scheduled meeting.

3. Category Two - Full Review:

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

SECTION 7. CONTINUING MEDICAL EDUCATION

- A. All Medical Staff members and others holding delineated clinical privileges are expected to obtain continuing medical education (CME) in order to maintain the expertise in their area of practice and to treat patients in an appropriate fashion.

Practitioners holding delineated clinical privileges will not be required to report CME credits if the following are satisfied:

1. The Idaho State Board of Medicine continues the requirement of 40 hours, every two years, of continuing medical education to renew state licensure; and
 2. The practitioner continues to hold a current unrestricted license to practice in the State of Idaho.
- B. All current providers holding delineated clinical privileges as of January 1, 2019 who prescribe pharmaceuticals will be required to complete and submit two (2) hours of AMA PRA Category I accredited Opioid education by June 30, 2019. Proof of completion shall be submitted to the Medical Staff Office. All providers who initially come on staff after January 1, 2019 and thereafter will be required to complete and submit the two (2) hours of Opioid education within 6 months of their start date.

CHAPTER X

PROCTORING: ONGOING/FOCUSED PROFESSIONAL PRACTICE EVALUATION

SECTION 1. FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICY

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

Evaluation Period

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

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

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

Terms of Evaluation

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

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

Duties/Responsibilities of Department Chairs

Each medical staff department chair shall be responsible for:

1. Assisting the department in establishing a minimum number of cases/procedures to be

- evaluated and determining when a proctor must be present. When there are privileges that cross specialty lines, the Credentials Committee shall determine the minimum number of cases/procedures to be reviewed;
2. Identifying the names of proctors.
 3. If at any time during a proctoring period, the proctor notifies the department chair that he/she has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), based on the recommendations of the proctor, the department chair shall then review the medical records of the patient(s) treated by the practitioner being proctored and shall:
 - a. Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient; or
 - b. Refer the case(s) for peer review pursuant to the Peer Review Policy; or
 - c. Recommend to Medical Executive Committee that:
 - Additional or revised proctoring requirements be imposed upon the practitioner;
 - Corrective action be undertaken pursuant to the Corrective Action Plan

Duties/Responsibilities of the Medical Staff Office

The Medical Staff Office shall:

1. Send a letter to the practitioner being evaluated and to any assigned proctor containing the following information:
 - a. Evaluation requirements as predetermined by the department or Credentials Committee;
 - b. The name of the practitioner being proctored and the proctor and proctoring forms to be completed; and
 - c. A copy of the Focused Professional Practice Evaluation Policy and Procedure
2. Develop a mechanism to track admissions, procedures and/or clinical practice patterns of the practitioner being evaluated;
3. For practitioners being proctored:
 - a. Provide information to appropriate hospital departments about practitioners being proctored, including the name of the proctor and a supply of proctoring forms as needed;
 - b. Periodically contact both the proctor and practitioner being proctored to ensure that proctoring and chart reviews are being conducted as required;
4. Periodically submit a report to departments and/or Medical Executive Committee of evaluation activity for all practitioners being evaluated; and
5. At the conclusion of the evaluation period, submit a summary report on each practitioner being evaluated to Credentials Committee and Medical Executive Committee.

Proctoring Procedure

Assignment of Proctor:

The Department Chair will appoint an eligible proctor(s). To the extent possible, the proctor(s) should be qualified and possess credentials similar to the practitioner being proctored.

When the situation exists in which no other physician in that department is qualified or credentialed to serve as a proctor or a conflict of interest has been declared, a physician with appropriate privileges from another department may be assigned or an outside proctor may be retained. An outside proctor may be granted temporary privileges to serve in a proctoring capacity.

Duties/Responsibilities of Practitioners Being Proctored

Practitioners being proctored shall:

1. Notify the proctor of each case where care is to be evaluated and, when required, do so in sufficient time to allow the proctor to observe or review concurrently. For elective surgical or invasive procedures where direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioner may arrange for proctoring by another member of the Medical Staff with appropriate independent privileges or admit and treat the patient; however, the practitioner must notify the proctor as soon as reasonably possible;
2. Have the prerogative of requesting from the department chair a change of proctor if disagreements with or incomplete proctoring duties by the current proctor may adversely affect his or her ability to satisfactorily complete the proctorship. The department chair will make a recommendation on this matter to the Medical Executive Committee for final action;
3. Inform the proctor of any unusual incident(s) associated with his/her patients;
4. Ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of proctorship forms and the summary proctor report to the Medical Staff Office. If the proctorship forms and the summary proctor report are not completed and submitted at the end of the initial proctoring period, the proctoring period will automatically extend for up to three (3) months. Following this automatic extension, the Credentials Committee may elect to further extend the proctoring period. If a practitioner fails to complete and deliver the proctorship forms and the summary proctor report to the Medical Staff Office by the end of a proctoring period extended under this subparagraph 4, regardless of the duration of the extension, such failure shall be treated as a voluntary relinquishment of the privileges which were subject to proctoring.

Duties/Responsibilities of the Proctor

The proctor shall:

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

- a non-provisional status or recommend an additional proctoring period and/or continued provisional staff status, or NOT recommend advancement or appointment; and
- h. For new or additional privileges, make a recommendation to independently perform the requested privileges or recommend an additional proctoring period, or NOT recommend continued clinical privileges as requested.
2. Complete proctoring forms and assure their confidentiality and delivery to the Medical Staff Office;
 3. Submit any additional information as necessary in addition to the proctor forms at the conclusion of the proctoring period;
 4. If at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the department chair and may recommend that:
 - a. The department chair intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient; or
 - b. The department chair review the case for possible peer review, pursuant to the Peer Review Policy; or
 - c. Additional or revised proctoring requirements be imposed upon the practitioner until the proctor can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored; or
 - d. The appointee's continued appointment and clinical privileges be referred to Medical Executive Committee.

Liability of Proctor

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

Completion of Proctorship

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

FPPE for Physician Performance Issues

Focused Professional Practice Evaluation shall be conducted when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high quality patient care which have been identified through the peer review process, ongoing feedback reports or pursuant to the Corrective Action Plan.

Triggers that may initiate this process include but are not limited to:

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

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

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

SECTION 2. MEDICAL STAFF FOCUSED REVIEW AND OPPE

Purpose

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

Policy

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

Confidentiality, Immunity, and Compliance with State Law

- A. All written records of interviews, reports, statements, minutes, memoranda, and all physical materials related to research, discipline or medical study utilized in the course of the Focused Review of Practitioner Performance and Ongoing Professional Practice Evaluation activities described in this policy and procedure shall be the property of Saint Alphonus Medical Center Nampa and shall be confidential to the full extent provided by Idaho state law, including, but not limited to, Idaho Code Section 39-1392.
- B. Participants in the Focused Review of Practitioner Performance and Ongoing Professional Practice Review activities described in this policy and procedure who furnish information or opinions related to research, discipline or medical study shall be granted immunity from liability to the full extent provided by Idaho state law, including, but not limited to, Idaho Code Section 39-1392.
- C. This policy and procedure is intended to comply with the requirements of Idaho Code Section 39-1392f for the organization of in-hospital medical staff Focused Review of

Practitioner Performance committees.

- D. Unauthorized disclosure of Department, Committee or legal information designated as confidential may result in disciplinary action or termination for Hospital employees and/or disciplinary action according to the Corrective Action Process outlined in the Medical Staff Bylaws for physicians.

Procedure

- A. There are six standard general competencies included in the concurrent and continuous monitoring of members of the medical staff which include:
 - 1. Patient care
 - 2. Medical/clinical knowledge
 - 3. Practice based learning and improvement
 - 4. Interpersonal and communication skills
 - 5. Professionalism
 - 6. System-based practice
- B. The performance dimensions for review to address the above competencies may include:
 - 1. Technical quality and knowledge: Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted
 - 2. Service quality: Ability to meet the customer service needs of patients and other caregivers
 - 3. Patient safety and rights: Cooperation with patient safety and patient rights, rules, and procedures
 - 4. Resource use: Effective and efficient use of hospital clinical resources
 - 5. Relations: Interpersonal interactions with colleagues, hospital staff, and patients
 - 6. Citizenship: Participation in and cooperation with medical staff responsibilities
- C. In addition to the hospital performance activities, each medical staff department within Saint Alphonsus Medical Center Nampa will identify rate-based or rule-based performance indicators used for ongoing surveillance and the thresholds for indicators prompting further review (see Addendum 2A).
 - 1. Ongoing Professional Practice Evaluation is conducted via aggregate data by the individual practitioner and compared to the available benchmarks.
 - 2. Ongoing feedback reports are provided to the Medical Staff more often than every twelve (12) months and at the time of reappointment for inclusion in the practitioner's reappointment profile.
 - 3. The reports are initially analyzed by the Physician Advisor for triggers and adverse trends. Findings and subsequent action, if applicable, are discussed by the Medical Staff Quality Committee (MSQC). The MSQC may provide recommendations to the Medical Executive Committee (MEC) when further intervention is needed (see Exhibit B).
- D. Medical Staff Quality Committee (MSQC)

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

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

Criteria for Reviews

Focused Review of Practitioner Performance may be initiated due to:

- Significant deviation from accepted standards of practice
- Adverse or negative performance trends
- Repeated failure to follow hospital policy
- Significant staff or patient complaint(s)
- Upon recommendation of the Department Chair

A. When an alleged concern involving a physician comes to the attention of the Quality Management Department:

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

B. Reporting

1. Any reporting and disciplinary action resulting from a Focused Review of Practitioner Performance shall be undertaken in accordance with the applicable Saint Alphonsus

- Medical Center Nampa Medical Staff Bylaws.
2. Aggregate findings should be reported to the MEC and may be reported to Credentialing and the Board.
 3. Documents shall be maintained securely and confidentially in the Quality Department, Risk Management, or Medical Staff Office.
 4. Any adverse recommendation that is reportable will follow the process outlined by the National Practitioner Data Bank. (See Exhibit A)

Definitions

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

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

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

ADDENDUM 2A:

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

Interpersonal and Communications Skills	
Complaints Involving Physician Behavior	3 or more
Practiced Based Learning and Improvement	
Core Measure Scores	Defined by Trinity
Core Measure Misses	2 or more
Adverse events related to moderate or deep sedation	2 or more
*Department Specific Indicators	Defined by departments
Professionalism	
Suspension Due to Delinquent Records	1 or more
	3 or more
System Based (2 charts audited per practitioner)	
<u>H&P Not Completed Within 24 Hours</u>	1 or more
<u>Orders Not Dated and Timed</u>	1 or more
<u>Illegible Orders</u>	1 or more
<u>Use of Unapproved Abbreviations</u>	1 or more

ADDENDUM 2B:

Focused Review of Practitioner Performance Final Case Ratings

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

Note

Controversial Care and Unacceptable Care are reviewed at MSQC and discussed with the Vice Chairs of the Departments for review at the next Medical Staff Department meeting.

Exhibit A: Focused Review of Practitioner Performance Process

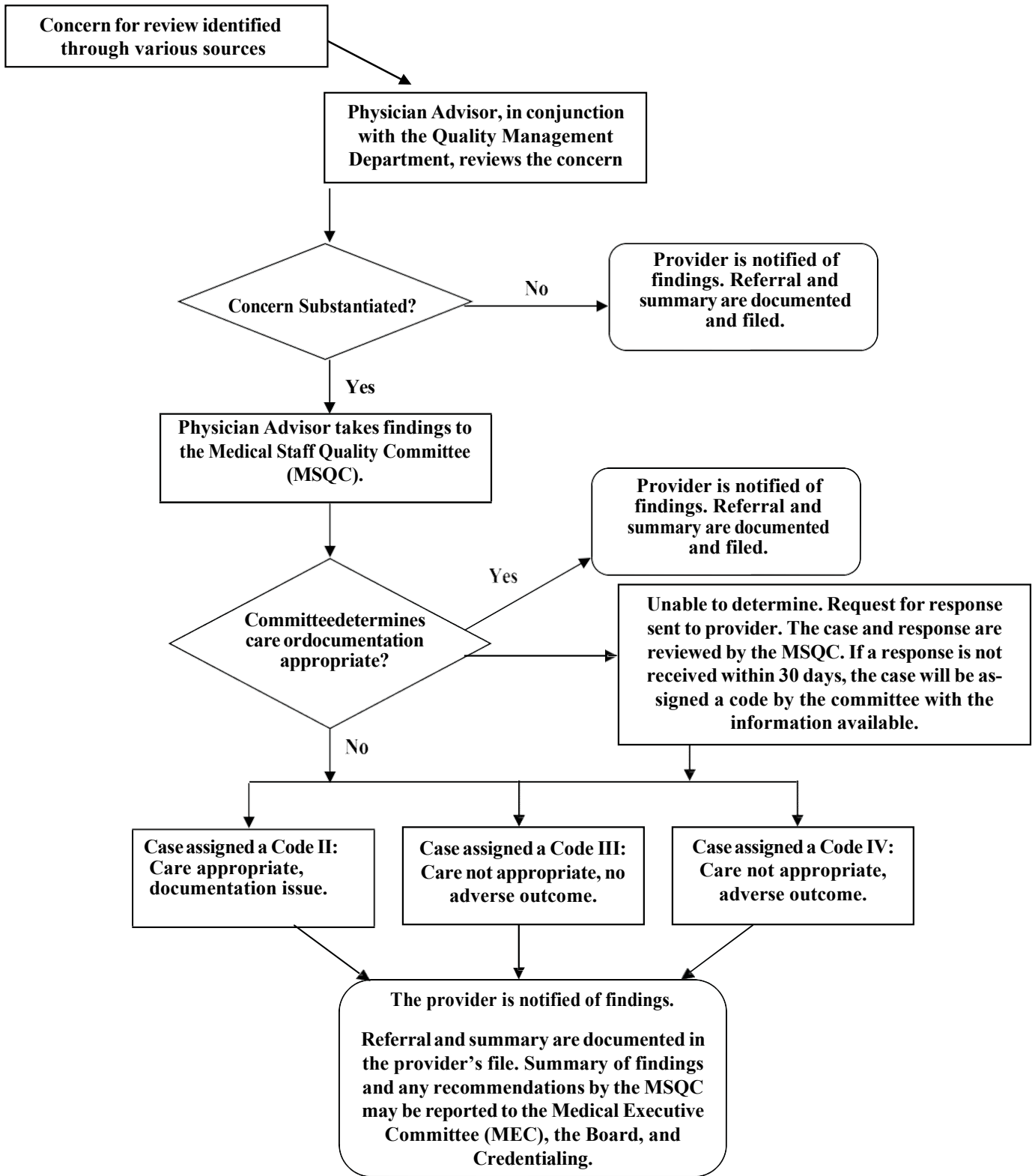
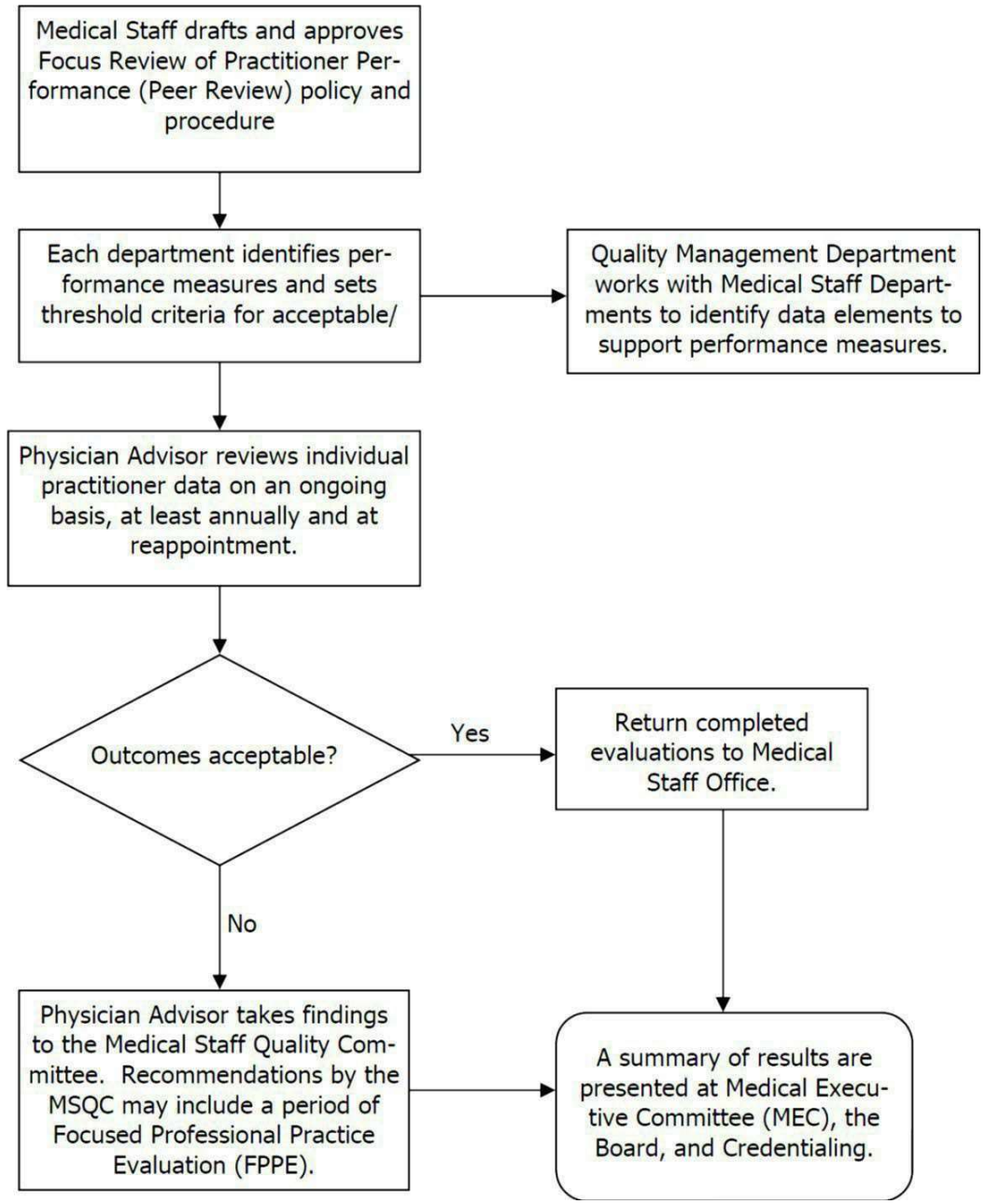


Exhibit B: Ongoing Professional Practice Evaluation (OPPE) Process



CHAPTER XI

COLLEGIAL INTERVENTION

SECTION 1. COLLEGIAL INTERVENTION POLICY

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

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

SECTION 2. CONDUCT

Purpose and Philosophy Statement

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

Definitions

Sexual Harassment: It is a violation of both state and federal law for a Hospital employee to be subjected to sexual harassment in the workplace. Sexual harassment, as prohibited by law, is distinguished from a voluntary sexual relationship by the elements of coercion, threat, unwanted attention, unwelcome or unwanted sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Verbal or physical conduct of a sexual nature constitutes sexual harassment when any of the following things occur:

- Submission to or rejection of such conduct is either implicitly or explicitly made a term or condition of employment or participation in Hospital activities.
- Submission to or rejection of such conduct by an individual is used as a basis for evaluation in making personnel decisions affecting an individual.

- Conduct unreasonably interferes with the performance or work of the individual or creates an intimidating, hostile or offensive work environment.

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

- Using threatening or abusive language directed at an individual or regarding another individual, including patients, nursing staff, other Hospital personnel or Practitioners (e.g., belittling, berating and/or threatening an individual).
- Making degrading, demeaning or insulting comments regarding patients, nursing staff, other Hospital personnel or the Hospital.
- Using profanity, racial slurs or similarly offensive language.
- Verbal, non-verbal or physical interaction with another individual that is reasonably perceived as threatening, intimidating or disruptive to the orderly operations of the Hospital.
- Addressing concerns about clinical judgment or dissatisfaction with the performance of another individual in the medical record or by other inappropriate means (instead of through direct and professional contact with the individual or through Medical Staff or Hospital policies).
- Refusing to utilize the electronic health record or any informational technology required for safe patient care or refusing to participate in training associated with the electronic health record or any informational technology required for safe patient care.

Scope of Policy

Place of Conduct That May Violate Policy

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

Application to Complaints About Practitioners

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

Corrective Action

This policy outlines a collegial procedure to attempt to address disruptive or unlawful harassing conduct by a Practitioner, and invoking the policy does not itself entitle a Practitioner to rights under the Bylaws' Fair Hearing Plan. However, notwithstanding the Medical Staff's desire to try to address these issues through the collegial procedure in this policy, this policy does not preclude immediate invoking of the Bylaws' Corrective Action Plan process at any time, if it is determined that the Practitioner's conduct so warrants. For example, if there is a single severe incident of conduct, or a repetitive pattern of conduct that is egregious, this collegial procedure may be

bypassed, and the Corrective Action Plan may be invoked. (If the Corrective Action Plan is invoked and the Practitioner's conduct results in an adverse action as defined in the Bylaws, then the Practitioner would be entitled to such rights as are outlined in the Fair Hearing Plan.)

Peer Review Confidentiality

The Investigation of a Practitioner under this policy is considered and intended by the Hospital and Medical Staff to be within the scope of Peer Review confidentiality as provided under Idaho Code Section 39-1392 et. seq.

Procedures for Documenting and Triaging Event Reports/Complaints

A. Reporting Conduct Potentially Violative of this Policy.

Complaints alleging disruptive conduct or unlawful harassment concerning a Practitioner should generally be reported and documented in the Hospital's event reporting system (e.g., VOICE or its successor). These reports/complaints, as well as any complaints which are otherwise reported or made, will be forwarded to the Event Report Triage Committee. The Event Report Triage Committee will review and triage them consistent with the guidelines in this policy.

B. Event Report Triage Committee.

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

C. General Triage Guidelines.

Issues are generally triaged by the Event Report Triage Committee as follows:

- All anonymous reports/complaints are retained for tracking and trending. Anonymous reports/complaints will be assessed by the Event Report Triage Committee and may be referred for such investigation as is possible to undertake under the circumstances.
- Reports/complaints that are evaluated as predominantly a result of system issues and involve a Practitioner who rarely has complaints filed against him or her may be referred to the manager of the area where the complaint occurred for further investigation and resolution.
- Reports or complaints may be forwarded to the Practitioner's Department Chair.
- Reports/complaints that are evaluated as predominantly system issues may be referred to other Committees or individuals (such as the manager of the area where the incident occurred) for follow up and or disposition.
- Reports/complaints that are deemed to potentially involve a quality of care component may be also forwarded for peer review.
- Reports/complaints that involve a Practitioner who has numerous or repetitive complaints may be referred to the MEC.

- Any reports/complaints of egregious behavior or behavior that appears to be a danger to patients or staff, no matter the frequency of the complaints against the Practitioner, are referred to OMA for distribution to the President and President-elect of the Medical Staff, the Vice President of Medical Affairs, Vice President of Quality and Patient Safety, the CEO, or their respective designees. Complaints of unlawful harassment involving hospital employees including employed Practitioners, will also be referred to the Manager of Employee Relations or other appropriate designee of Human Resources.

D. Practitioner Notification.

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

E. Further Evaluation of Report/Complaint

1. Referral to the MEC or other Investigator.

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

- a. When evaluating how to proceed, the Event Report Triage Committee will consider the facts and circumstances alleged, including but not limited to the severity and frequency of the complained of conduct, information available that verifies the conduct (such as witnesses reports confirming the conduct), any prior complaints about the Practitioner and the Practitioner's attitude and willingness to professionally address the concerns raised, if known.
- b. If the Event Report Triage Committee determines the matter cannot be or was not able to be resolved informally, or if it is a repeated incident or an egregious incident, or number of incidents, the Event Report Triage Committee will forward the complaint to the MEC or another appropriate investigator(s) ("Investigator") to complete a review of the report/complaint and/or conduct an investigation. Alternatively, if the Event Report Triage Committee feels the allegations warrant, it may refer a matter to one of the individuals listed in the Bylaws for precautionary suspension and/or initiation of an investigation under the Corrective Action Plan. If that occurs, the process outlined in that Corrective Action Plan will then apply to the review of the matter, rather than this policy.

- c. Risk Management, the Event Report Triage Committee will investigate most complaints; however, if another Investigator is chosen, consideration will be given to the source of the report/complaint. For example, an employee report/complaint could be investigated by the HR Employee Relations Manager or designee, a Practitioner complaint could be investigated by a Department Chair, and a patient complaint could be investigated by the appropriate nursing leader or by designated members of the ERTC).
2. Evaluation of All Reports/Complaints.
Anonymous reports or complaints will be followed up to the extent possible. Requests that a complaint is “for information purposes only” or that “nothing should be done” generally should not be accommodated. If a Complainant wishes to withdraw the complaint, or makes a further report that he or she reported inaccurate information, the withdrawal and/or change will be documented and signed. Withdrawal of the complaint will not, however, affect the Medical Staff or Hospital’s ability to proceed with an investigation or other action pursuant to this policy, or the Medical Staff Bylaws, as appropriate.
3. Investigation Process.
 - a. The Investigator(s) will conduct a thorough of an investigation as possible, in a manner that is reasonably confidential under the circumstances. Whenever feasible, the Investigator will conduct the investigation within ten (10) business days of receiving the report/complaint from the Event Report Triage Committee or as soon as is reasonably possible.
 - b. The investigation will include interviews with any witnesses and discussions with both the Complainant and the Practitioner, who will be advised of the contents of the complaint and be given an opportunity to respond to the allegations.
 - c. The Investigator will determine whether the complained of conduct occurred or likely occurred. The Investigator will prepare a written report and summary of the investigation and provide it to the ERTC. The Investigator may also be asked to meet with the Medical Staff President or ERTC members to answer questions regarding the report and conclusions.
 - d. If the Investigator finds that in his or her judgment the weight of the evidence is that the complained of conduct has occurred and this policy has been violated, he or she will inform the ERTC and the matter will proceed as outlined in Section F Below.
 - e. If the Investigator finds that in his or her judgment the weight of the evidence is that the complained of conduct did not occur and/or did not violate this policy, the ERTC will be so advised and the Complainant and the Practitioner will be notified in writing by the Medical Staff President. If there is information which may indicate that other policies have been violated, then the ERTC will make a referral for further investigation and action to other appropriate Medical Staff or Hospital bodies.

F. Final Meeting with the Practitioner and Communication of Findings

1. If the Investigator determines there has been a policy violation, the Practitioner will be

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

G. Remedial Options for Policy Violations

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

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

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

H. No Abuse of Policy Tolerated

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

I. No Retaliation Policy

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

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

J. Reappointment

The duration of reappointment may be shortened in order to complete assessment or

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

SECTION 3. POLICY ON ASSISTING THE IMPAIRED LICENSED INDEPENDENT PRACTITIONER

Statement of Purpose

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

Definitions

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

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

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

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

Chief Executive Officer. For the purpose of this policy, the “Chief Executive Officer” is the Chief Executive Officer of the Hospital or an individual designated by the Chief Executive Officer to act on his/her behalf to carry out the duties of the Chief Executive Officer as set forth in this policy.

Well-Being Committee. For the purpose of this policy, the “Well-Being Committee” means the Well-Being Committee referred to in the Medical Staff Bylaws.

A. Self-Referral

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

B. Report and Investigation

Scope of Policy

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

Procedure

1. Report.

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

Upon receiving such a report, the Chief of Staff shall promptly advise the member, in writing, that a report has been filed.

2. Initial Evaluation.

After receipt of a report concerning a Licensed Independent Practitioner’s potential impairment, the Chief of Staff, in consultation with the Chief Executive Officer, or their designees, shall evaluate whether it appears there is sufficient evidence to warrant further investigation of the report. If so, the Chief of Staff or his or her designee may:

- a. Meet personally with the Licensed Independent Practitioner;
- b. Give the Licensed Independent Practitioner an opportunity to make a self-referral pursuant to Section A above; and/or
- c. Direct in writing that an investigation be instituted and a report and recommendation

be rendered by the Well-Being Committee.

3. Investigation.

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

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

4. Classification of Impairment.

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

5. Recommendation.

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

6. Communication of Action.

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

7. Confidentiality/Documentation of Investigation.

- a. The Hospital's investigation and evaluation of a Licensed Independent Practitioner's potential impairment shall be confidential and shall be conducted pursuant to the Idaho Peer Review Statute, Idaho Code Section 39-1392, *et seq.* All participants in the investigation shall refrain from discussing the investigation with anyone outside of the process described in this policy.
- b. The report of potential impairment and the Well-Being Committee's recommendation shall be included in the Licensed Independent Practitioner's confidential file. The Licensed Independent Practitioner who is the subject of any such report may also submit a written report which shall be included with the report of potential impairment and the recommendation of the Well-Being Committee in the Licensed Independent Practitioner's confidential file.

8. No Abuse of Policy.

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

C. Impairments Classified as a Disability Under the ADA

1. Applicability.

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

2. Reasonable Accommodation.

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

- a. Whether the Hospital is able to make a reasonable accommodation that would enable the Licensed Independent Practitioner to competently and safely perform his/her clinical privileges and the duties and responsibilities of his/her appointment;
- b. Whether such reasonable accommodation would create an "undue hardship" upon the Hospital in that the reasonable accommodation would be excessively expensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and
- c. Whether the impairment constitutes a "direct threat" to the health or safety of the Licensed Independent Practitioner, patients, staff, or others within the Hospital. A direct threat must involve a significant risk of substantial harm based upon medical analyses and/or other objective evidence. If the Licensed Independent Practitioner appears to pose a direct threat because of his/her impairment, the Well-Being Committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level through a reasonable accommodation.

3. Voluntary Agreement.

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

4. Other Recommendation.

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

D. Impairments Not Classified as a Disability Under the ADA

1. Applicability.

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

2. Recommendation.

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

- a. If the Licensed Independent Practitioner affirms the existence of the impairment and agrees to fully cooperate and comply with an appropriate course of rehabilitation, the Licensed Independent Practitioner may be placed on a medical leave of absence for purposes of participation in an appropriate rehabilitation program, subject to the provisions of Section E below and the procedure and approval required by the Medical Staff Bylaws for a leave of absence;
- b. If the Licensed Independent Practitioner either denies the existence of an impairment or fails to fully cooperate with or fails to complete the required course of rehabilitation, the Well-Being Committee shall recommend action to the Executive Committee. If the Well-Being Committee's recommendation entitles the Licensed Independent Practitioner to a hearing under the Medical Staff Bylaws, the Executive Committee shall promptly notify the Licensed Independent Practitioner of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Chief Executive Officer or the Board until the Licensed Independent Practitioner has exercised or has been deemed to have waived the right to a hearing as provided in the Medical Staff Bylaws.
- c. If grounds for precautionary review rights or precautionary suspension under the

Medical Staff Bylaws are satisfied, precautionary suspension shall be imposed.

E. Rehabilitation and Reinstatement

1. Rehabilitation.

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

2. Eligibility for Reinstatement.

Upon sufficient proof that an impaired Licensed Independent Practitioner has successfully completed a PRN sanctioned rehabilitation program, the Hospital, at its discretion, may consider the Licensed Independent Practitioner eligible for reinstatement to the Medical Staff. Sufficient proof includes but is not limited to a letter from the director of the rehabilitation program where the Licensed Independent Practitioner was treated confirming that:

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

3. Reinstatement.

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

- a. The impaired Licensed Independent Practitioner must identify another Licensed Independent Practitioner who is willing to assume responsibility for the care of the impaired Licensed Independent Practitioner’s patients in the event of his/her inability or unavailability;
- b. The impaired Licensed Independent Practitioner shall be required to obtain periodic reports from his/her primary care physician or monitoring physician for a period of time specified by the chairperson of the Licensed Independent Practitioner’s department or the Chief of Staff, verifying that the Licensed Independent Practitioner is continuing treatment or therapy, and that his/her ability to treat and care for patients in the Hospital is not impaired;
- c. The Licensed Independent Practitioner’s exercise of clinical privileges in the Hospital

shall be monitored by the chairperson of the Licensed Independent Practitioner's department or his/her designee; and

- d. The Licensed Independent Practitioner must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer, the Chief of Staff, or the chairperson of the Licensed Independent Practitioner's department.
4. **Aftercare Programs/Monitoring.**
Any aftercare programs and/or monitoring will be coordinated by the PRN based on the aftercare program prescribed by the director of the rehabilitation program. In order to ensure appropriate aftercare treatment, the impaired Licensed Independent Practitioner will be required to sign and comply with an aftercare contract with the PRN.

CHAPTER XII

MISCELLANEOUS

SECTION 1. DISASTERS

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

SECTION 2. RESEARCH ACTIVITIES

- A. Participation in research projects by Medical Staff appointees is encouraged. To ensure adequate compliance with any applicable guidelines and laws, Medical Staff appointees shall consult with and obtain the approval of the Chief Executive Officer regarding any research projects in which they propose to participate.
- B. Policy considerations pertaining to medical and/or scientific research projects of the Medical Staff shall be reviewed by the Executive Committee and by the Chief Executive Officer.
- C. The results of all research projects, clinical, statistical or otherwise, and all publications written or provided by Medical Staff appointees using the name of this Hospital, must be submitted to the Chief Executive Officer for approval prior to any publication.
- D. As defined in the Institutional Review Board Policy, specific protocols are to be followed and specific consents are to be obtained in cases where any investigational pharmaceuticals or medical devices are to be used. Such protocols and consents are to be submitted to the Institutional Review Board for approval and renewal.

SECTION 3. ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)

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

- A. Participants.
The participants are the Hospital and Members of the Medical Staff and Practitioners at the Hospital.
- B. Hospital.
The Hospital consists of the following locations: Saint Alphonsus Medical Center and Saint Alphonsus Nampa Health Plaza.
- C. Scope of OHCA activities.
The scope of the OHCA between the Hospital, Members of the Medical Staff (“Member”) and Practitioners is limited to the locations in (b) above. The OHCA and these Policy and Plans do not apply to:

1. The Member or Practitioner's independent professional services or individual practice's privacy practices. (For example, the OHCA does not apply to the Member's office practice's use and disclosure of its individually identifiable health information that is maintained by the Member's office for treatment, payment and operations).
2. Activities unrelated to Privacy Practices. The rule does not imply joint and several responsibilities between Hospital, the Member or Practitioner for the provision of clinical services. The Member or Practitioner is an independent provider of clinical services and these policy and plans do not alter in any way the independent status of the individual.

D. Notice of Privacy Practices:

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

E. Records and Designated Record Sets:

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

F. Voluntary Restrictions:

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

G. HIPAA Compliance Plan, Policies and Procedures:

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

SECTION 4. CONFIDENTIALITY OF MEDICAL STAFF INFORMATION POLICY

A. Definitions

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

B. Purpose

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

C. Participation in Reliance in Confidentiality

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

D. Preservation of Confidentiality

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

E. Corrective Action for Breach of Confidentiality

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

F. Location and Security Precautions

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

G. Access by Persons Within the Hospital and Medical Staff

1. Means of Access:

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

Medical Staff officers, the President of the Medical Staff, Medical Staff committee or department members, members of the Board, the Medical Staff Coordinator, the Chief Executive Officer, or authorized representative, and any other persons assisting in credentialing/peer review or performance improvement activities may have access to Medical Staff Records, other than their own, to the extent necessary to perform their official functions. More particularly:

 - a. Medical Staff Officers: Medical Staff officers shall have access to all Medical Staff Records to the extent necessary to perform their official functions.
 - b. Medical Staff Committee/Department Members: Medical Staff committee/department members shall have access to the records of committees/departments on which they serve and to the credentials/peer review and performance improvement files of members whose qualifications or performance the committee/department is reviewing as part of its official functions.
 - c. Chief Executive Officer/Designated Representative: The Board and the Chief Executive Officer, as its designated representative, shall have access to the Medical Staff Records to the extent necessary to perform their official functions.
 - d. Medical Staff: The Medical Staff shall have access to the Medical Staff Records to the extent necessary to perform official functions.
3. General Access by Members to Medical Staff Records:
 - a. Credentials/Peer Review Files: A member will have access to the credentials/peer review files of other members only as set out above. A member may have copies of any documents in the credentials/peer review file, which he submitted (that is, his initial appointment application, application for reappointment, request for privileges or correspondence from himself) or which were addressed to him or of which copies were earlier provided to him. A member will be allowed access to further information in his credentials/peer review file only if, following a written request by the member, the Executive Committee and either the Board or its designated representative grant written permission for good cause.
 - b. Medical Staff Committee/Department Files: Except as provided above, a member shall be allowed access to Medical Staff committee/department files (including committee/department minutes) only if, following a written request by the member,

the Executive Committee and either the Board or its designated representative grant written permission for good cause.

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

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

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

- a. Information contained in a credentials/peer review file, or other information, which is subject to this policy, may be released in response to a request from another health care facility or its Medical Staff. That request must include information that the member is a member of the requesting facility's Medical Staff, exercises privileges at the requesting facility, is an applicant for Medical Staff membership or privileges at that facility, seeks to be a managed care participant, or is an applicant for Medical Staff membership or privileges at that facility, and must include a release for such records signed by the concerned member. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.
- b. If a member has been the subject of corrective action at this Hospital, special care must be taken. All responses to inquiries regarding that member shall be reviewed and approved by the President of the Medical Staff, or his designee, and the Chief Executive Officer, or his designee.

2. Request by Hospital Surveyors:

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

- a. no originals or copies may be removed from the premises;
- b. access is only with the concurrence of the President of the Medical Staff, or designee, and Chief Executive Officer, or designee; and the surveyor demonstrates the following:
 - specific statutory, regulatory or other authority to review the requested materials;
 - that the materials sought are directly relevant to the matter being investigated;
 - that the materials sought are the most direct and least intrusive means to carry out the survey or a pending investigation, bearing in mind that credentials/peer review files regarding individual members are confidential, so long as inspection does not invalidate the privileges contained in Title 39, Chapter 13 of the Idaho Code;
 - sufficient specificity to allow for the production of individual documents without undue burden to the Hospital or Medical Staff; and

- in the case of requests for documents with member identifiers not eliminated, the need for such identifiers.

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

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

3. Subpoenas:

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

4. Other Requests:

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

I. Credential File Changes

1. Correction or Deletion:

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

- a. When a member has reviewed his file, as provided under this policy, he may address to the President of the Medical Staff and Chief Executive Officer a written request for correction or deletion of information in his credentials file. Such request shall include a statement of the basis for the action requested.
- b. he President of the Medical Staff and Chief Executive Officer shall review such request within a reasonable time and shall recommend to the Executive Committee, after such review, whether or not to make the correction or deletion requested. The Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.
- c. The member shall be notified promptly, in writing, of the decision of the Executive Committee.
- d. In any case, a member shall have the right to add to his own credentials file, upon

written request to the Executive Committee, a statement responding to any information contained in the file.

2. Notice to Members:

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

- a. The required authorization of the President of the Medical Staff and Chief Executive Officer has been granted to disclose, as required by law, information contained in the member's credentials file; and
- b. Adverse information is to be entered into his credentials file.
The notice of adverse information shall offer the member an opportunity to refute the adverse information before it is entered into the file.

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

**APPENDIX A
CONFIDENTIALITY AND NOTIFICATION STATEMENT**

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

- 1. To preserve the confidentiality of those records to the extent allowed by law, disclosing that information only as necessary for completion of the peer review process; and
- 2. To notify the Hospital prior to any further disclosure of that information outside the purpose stated below, whether pursuant to subpoena or otherwise, and to cooperate with any efforts of the Hospital to contest that disclosure.
- 3. Reason for review:

(Signature of Reviewer)

(Witness)

(Date)

(Date)

SECTION 5. SUPERVISION OF RESIDENTS

A. Policy

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

B. Purpose

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

C. Responsibility

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

D. Direct Supervision

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

E. General Guidelines

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

Reports related to clinical rotations of all Residents are provided to the Credentials Committee, the Medical Executive Committee and the Board of Directors. The Medical Staff Office will provide house-wide notification of approved clinical rotations.

F. Residents

Residents are graduate medical students in temporary attendance at the hospital in a training capacity under the supervision of members of the Active Medical Staff.

1. Qualifications

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

2. Credentialing

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

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

3. Scope of Activities

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

admission.

- f. Deliveries: Residents may participate in deliveries under the direct supervision of the Supervising Physician.
4. Supervising Physician Responsibilities
 - a. The identity of the Supervising Physician shall be readily available to hospital and medical staff so individuals know whom to contact should a question arise.
 - b. The Supervising Physician Must:
 - Be a member of the Active Medical Staff at Saint Alphonsus Medical Center – Nampa, Inc..
 - Be available (or designate an alternate physician to be available) either in person or through other means, to provide consultation when requested and to intervene when necessary.
 - c. Retain ultimate responsibility for the patient care rendered and ensure that all delegated activities are within the scope of the Resident training and experience.
 - d. Direct and review the work, records, and practice of the Resident on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered.
 - e. Report any concerns related to the quality of care, treatment and services, and educational needs of/by the Resident, to the Medical Executive Committee for review. The Medical Executive Committee may report such concerns to the appropriate training program.
 5. Residents MAY NOT:
 - a. Make rounds in lieu of the supervising physician
 - b. Take call for the supervising physician
- G. Saint Alphonsus Medical Center – Nampa, Inc. reserves the right to place conditions on the clinical rotation if it is deemed in the best interest of the hospital, the physicians, hospital staff, or for the safety and consideration of patients.
- H. At the conclusion of the scheduled rotation, all previously approved scope of activities is terminated.

**ANNUAL RESIDENT COMPETENCY
REPORT FOR ACADEMIC OR CALENDAR
YEAR _____**

During the academic year of 20____, Saint Alphonsus Medical Center Nampa hosted _____ Residents from the following Graduate Medical Education Programs:

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

City State

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

The following are related to Resident Performance:				
	Involvement In Any Sentinel Events?	Reported Incidents Involving Residents?	Resident Evaluations Received And Resident Did Not Meet Requirements or Rotation Experience?	Concerns Related to Resident Performance Including Clinical Competency and Behavioral Issues?
Resident Name: Supervising Physician:				
Resident Name: Supervising Physician:				
Resident Name: Supervising Physician:				
Resident Name: Supervising Physician:				
Resident Name: Supervising Physician:				

Resident/resident competency report 122010.doc – Approved 01/04/201

SECTION 6. CONFLICT MANAGEMENT POLICY

Policy

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

Hospital Leadership Meetings

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

Medical Staff Leadership Meetings

Medical Executive Committee

Medical Staff Meetings

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

Board Meetings

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

Procedure

The Conflict Management Process:

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

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

The Board Chair and/or the Board shall make the final decision as to the conflict.

Documentation

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

ORGANIZATION MANUAL

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CHAPTER I

CLINICAL DEPARTMENTS

SECTION 1. LIST OF DEPARTMENTS

The following clinical departments are established:

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

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

SECTION 2. FUNCTIONS OF DEPARTMENTS

- A. Each clinical department shall recommend to the Credentials Committee written criteria for the granting of clinical privileges within the department. Such criteria shall be consistent with and subject to the bylaws, policies and procedures and policy and plans of the Medical Staff and Hospital. Clinical privileges shall be based upon demonstrated current competence, training and experience.
- B. Each department shall monitor and evaluate medical care questions and problems on a retrospective, concurrent and/or prospective basis in all major clinical activities of the department using data and information from hospital patient cases. This monitoring and evaluation must include at least:
 1. The identification and collection of information about important aspects of care provided in the department;
 2. The identification of the indicators used to monitor the quality and appropriateness of the important aspects of care; and
 3. The evaluation of the quality and appropriateness of care
- C. Each department shall recommend, subject to approval and adoption by the Executive Committee and Board, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or by the Hospital's Quality Management Department to monitor and evaluate patient care. When important problems in patient care and clinical performance or opportunities to improve care are identified, each

- department shall document the actions taken and evaluate effectiveness of such actions.
- D. In discharging these functions each department shall report to the Executive Committee after each meeting detailing its analysis of patient care, whenever further investigation and appropriate action involving any individual member of the department is indicated. Copies of these reports shall be filed with the Executive Committee and the Chief Executive Officer.
 - E. Each department shall establish and maintain such policies, protocols and procedures as are necessary. All such policies, protocols, and procedures shall be consistent with the objectives of the Board and consistent with these Bylaws and the Medical Staff Policy and Plans.

SECTION 3. DEPARTMENT CHAIRMAN

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

SECTION 4. FUNCTIONS OF DEPARTMENT CHAIRMAN

Each chairman shall:

- A. be responsible for the clinical and administrative activities within the department;
- B. be a member of the Executive Committee;
- C. be responsible for continuous assessment and improvement of the quality and appropriateness of patient care, treatment and services provided within the department;
- D. monitor the professional performance of all individuals who have delineated clinical privileges in the department, and make recommendations thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
- E. recommend criteria for clinical privileges in the department
- F. recommend a sufficient number of qualified and competent individuals to provide clinical services;
- G. be responsible for the integration of the department into the primary functions of the Hospital;
- H. be responsible for the coordination and integration of interdepartmental and intradepartmental services;
- I. be responsible for the development and implementation of policies and procedures that guide and support the provision of services;
- J. be responsible for maintenance of quality control programs, as appropriate;
- K. appoint ad hoc committees or working groups as necessary to carry out Performance

- Improvement activities;
- L. make a recommendation to the Credentials Committee concerning the appointment, reappointment and delineation of clinical privileges for all applicants seeking privileges in the department;
 - M. be responsible for the evaluation of all provisional appointees and recommend thereon to the Credentials Committee;
 - N. assist the Hospital, in accordance with the provisions of these Bylaws, with respect to the evaluation and granting of requests for temporary privileges;
 - O. be responsible within the department for the enforcement of these Bylaws and the policies and procedures and policy and plans of the Medical Staff;
 - P. be responsible for implementation within the department of actions taken by the Board and the Executive Committee;
 - Q. be responsible for the establishment, implementation and effectiveness of the orientation, teaching, education and research programs in the department;
 - R. report and recommend to Hospital Administration off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital.
 - S. recommend space and other resources needed by the department.
 - T. assist Hospital Administration in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Chief Executive Officer or the Board;
 - U. delegate review of applications for appointment, reappointment or clinical privileges, or questions that may arise to the vice-chairman or other member of the department, if he has a conflict of interest with the individual under review, or could be reasonably perceived to be biased;
 - V. delegate to the vice-chairman or other members of the department such other duties as he deems appropriate;
 - W. comply with the provisions of Chapter III in the Organizational Manual; and
 - X. determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

CHAPTER II

COMMITTEES OF THE MEDICAL STAFF

CHAPTER II - PART A: APPOINTMENT

SECTION 1. CHAIRMEN

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

SECTION 2. MEMBERS

- A. Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed annually by the President at the beginning of the Medical Staff Year, in consultation with the Chief Executive Officer, if requested. All appointed members may be removed and vacancies filled by the President at his discretion.
- B. The Chief Executive Officer and the President or their respective designees shall be members, ex-officio without vote, of all committees, unless otherwise expressly provided.
- C. Committee members must comply with Chapter III in the Organization Manual.

CHAPTER II - PART B: EXECUTIVE COMMITTEE

SECTION 1. COMPOSITION

- A. The Executive Committee shall consist of the President, President-Elect, Secretary/Treasurer of the medical staff, a Hospitalist representative, and the chairman of each clinical department. The chairman of the Credentials Committee shall be a member, ex-officio, without vote.
- B. The Executive Committee includes physicians and may include other licensed independent practitioners.
- C. The President shall be chairman of the Executive Committee.
- D. The Chief Executive Officer and Vice President of Medical Affairs, or their designees, attends meetings of the Executive Committee and may participate in its discussions, but without vote.
- E. The Chairman of the Board, or his designee, may attend meetings of the Executive Committee and participate in its discussions, but without vote.
- F. Members of the Executive Committee may not hold more than one (1) Medical Staff office simultaneously. (President, President-Elect, or Secretary Treasurer)
- G. No fully licensed medical staff member actively practicing in the hospital is ineligible for membership on the Executive Committee solely because of his or her professional discipline or specialty.

SECTION 2. DUTIES

The duties of the Executive Committee shall be:

- A. to represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;
- B. to coordinate the activities and general policies of the various departments;
- C. to implement policies of the Medical Staff which are not the responsibilities of the departments;
- D. to provide liaison among the Medical Staff, the Chief Executive Officer and the Board;
- E. to recommend action to the Chief Executive Officer on matters of medico-administrative and Hospital administrative nature;
- F. to ensure that the Medical Staff is kept abreast of Conditions of Participation from the Centers of Medicare and Medicaid (CMS) and the Standards from The Joint Commission (TJC) and informed of the accreditation status of the Hospital;
- G. to take steps to ensure the enforcement of Hospital and Medical Staff bylaws, policy and plans, policies and procedures in the best interest of patient care and of the Hospital on the part of all persons who hold appointment to the Medical Staff, and to make recommendations to the Board on actions described in Articles I, VII, IX, X and XI;
- H. to refer situations involving questions of the clinical competence, patient care and treatment or case management of any persons who hold appointments to the Medical Staff to the Credentials Committee or to the Medical Staff Quality Committee, as appropriate.
- I. to request evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;
- J. to be responsible to the Board for the quality of professional services rendered to patients in the Hospital;
- K. to determine minimum continuing education requirements for appointees to the Staff;
- L. to make recommendations to the Board on the following matters:
 - the Medical Staff membership;
 - the Medical Staff structure;
 - the mechanism used to review credentials and delineate individual clinical privileges, including criteria for clinical privileges and Focused Professional Practice Evaluation (FPPE);
 - recommendations of individuals for Medical Staff appointment and reappointment;
 - recommendations for delineated clinical privileges for each practitioner privileged through the medical staff process;
 - the participation of the Medical Staff in performance improvement activities;
 - the mechanism by which Medical Staff appointment may be terminated;
 - the mechanism for fair hearing procedures;
 - the appropriateness, clinical necessity, and timeliness of support services provided directly by the hospital or through referral contacts; and
 - the Executive Committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups.

- M. to review, evaluate, and revise the Medical Staff peer review and Quality Improvement activities on a regular basis; and
- N. to participate in quality assurance and improvement and peer review activities as set forth in the Idaho Code Sections 39-1392 through 39-1392f.

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

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

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

SECTION 4. MODIFICATION OF DUTIES

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

CHAPTER II - PART C: HEALTHCARE ETHICS ADVISORY COMMITTEE

SECTION 1. COMPOSITION

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

SECTION 2. DUTIES

The duties of the Healthcare Ethics Advisory Committee shall be:

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

appropriate by the committee or as requested by the Medical Staff, Hospital Administration or Hospital staff;

- C. to assist and support the development of health care ethics educational programs according to the philosophy of health care of the Hospital and in cooperation with the Department of Educational Resources;
- D. to explore current ethical issues and to anticipate ethical dilemmas and questions which may arise as a result of scientific progress in medicine and the lifesciences;
- E. to provide a forum for the resolution of disagreements where ethical questions are concerned that arise among staff, patients and families concerning course of care while at the Hospital; and
- F. to participate in quality assurance, performance improvement and peer review activities as set forth in the Idaho Code Sections 39-1392 through 39-1392f.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

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

CHAPTER II - PART D: BYLAWS COMMITTEE

SECTION 1. COMPOSITION

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

SECTION 2. DUTIES

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

SECTION 3. MEETINGS, REPORTS, AND RECOMMENDATIONS

The Bylaws Committee will meet as requested by its chairman or the President and shall make reports and recommendations to the Executive Committee as needed.

CHAPTER II - PART E: CREDENTIALS COMMITTEE

SECTION 1. COMPOSITION

The Credentials Committee will consist of the following:

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

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

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

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

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

SECTION 2. DUTIES

The duties of the Credentials Committee shall be:

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

- the Executive Committee for the granting, reduction or withdrawal of promotions, privileges, reappointments, and changes in the assignment of appointees to the various departments;
- E. to review reports concerning the clinical privileges of Medical Staff appointees referred by any other Medical Staff committee, the President, the Chief Executive Officer or the Chairman of the Board and to make such recommendations as provided by these Bylaws; and
 - F. to participate in quality assurance, performance improvement and peer review activities as set forth in the Idaho Code Sections 39-1392 through 39-1392f.

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

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

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

CHAPTER II - PART F: PHARMACY AND THERAPEUTICS COMMITTEE

SECTION 1. COMPOSITION

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

SECTION 2. DUTIES

The Pharmacy and Therapeutics Committee shall be responsible for:

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

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Pharmacy and Therapeutics Committee shall meet quarterly or as often as necessary to conduct business, shall maintain a permanent record of its findings, proceedings and actions, and

shall make a report thereof after each meeting to the Executive Committee and the Chief Executive Officer.

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

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

CHAPTER II - PART G: INFECTION PREVENTION AND CONTROL COMMITTEE

SECTION 1. COMPOSITION

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

SECTION 2. DUTIES

The Infection Prevention and Control Committee shall be responsible for:

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

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

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

committee involving questions of professional ethics, infraction of Hospital or Medical Staff bylaws or policy and plans or unacceptable conduct on the part of any individual appointed to the Medical Staff.

CHAPTER II - PART H: MEDICAL STAFF QUALITY COMMITTEE

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

SECTION 1. COMPOSITION

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

SECTION 2. DUTIES

Processes are outlined in the policy on Medical Staff Focused Review of Practitioner Performance and Ongoing Professional Practice Evaluation.

The Medical Staff Quality Committee shall:

- A. Conduct Focused Review of Practitioner Performance (Peer Review) as set forth in the Idaho Code Sections 39-1392-1392f. This review shall include:
 - Categorization of the care by established codes;
 - Consideration of system factors that may contribute to the outcome; and
 - Identification of opportunities for improvement and, when identified, an action plan.
- B. analyze adverse patterns and trends that are relevant to an individual's performance, as identified in ongoing professional practice evaluations;
- C. examine utilization review and corporate compliance issues;
- D. with input from Medical Staff Departments and through the Focused Review of Practitioner Performance and Ongoing Professional Practice Evaluation process, be involved in the measurement, assessment and improvement in the following:
 - Medical assessment and treatment of patients;
 - Coordination of care, treatment, and services with other practitioners and Hospital personnel, as relevant to the care, treatment, and services of an individual patient;
 - Education of patients and families;
- E. Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process to determine whether to continue, limit or revoke any existing privilege(s);

- F. Appropriate clinical practice patterns;
- G. Significant departures from established patterns of clinical practice;
- H. Use of medications;
- I. Use of blood and blood components;
- J. Operative and other procedures;
- K. Sentinel Event data;
- L. Patient safety data;
- M. Infection Prevention and Control; and
- N. Accurate, timely, and legible completion of the patient’s medical records

SECTION 3. OTHER FOCUSED REVIEW OF PRACTITIONER PERFORMANCE (PEER REVIEW) PROCESSES

The following chairs are responsible for conducting Focused Review of Practitioner Performance in their respective Departments and/or Committees:

- Emergency Medicine;
- Pathology;
- Radiology; and
- Infection Prevention and Control.

SECTION 4. MEETING FREQUENCY AND REPORTING REQUIREMENTS

The Medical Staff Quality Committee shall meet at least quarterly, or as often as necessary, to conduct business, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Executive Committee and to the Board Quality Committee.

CHAPTER II - PART I: WELL-BEING COMMITTEE

The Well-Being Committee is an ad hoc committee appointed by the medical staff.

SECTION 1. COMPOSITION

The Well-Being Committee shall be composed of no fewer than three (3) Active Medical Staff members, a majority of whom, including the Chairman, shall be physicians and one of whom should be a psychiatrist or a member of the Family Practice Department.

SECTION 2. DUTIES

- A. The Well-Being Committee shall investigate, report, and make recommendations related to the health, well-being, or impairment of Medical Staff members as set forth in the Medical Staff Policy on Assisting the Impaired Licensed Independent Practitioner found in the Policy and Plans, Chapter XI, Section 2.
- B. The Committee shall also consider general matters related to the health and well- being of

Medical Staff members and, with the approval of the Executive Committee, develop educational programs or related activities.

- C. The Committee shall participate in quality assurance, performance improvement and peer review activities as set forth in the Idaho Code Sections 39-1392-39-1392f.

SECTION 3. REPORTS AND RECOMMENDATIONS

The Committee shall meet as often as necessary. It shall maintain only such records of its proceedings as it deems advisable and shall report on its activities as set forth in the Medical Staff Policy on Assisting the Impaired Medical Staff Member.

CHAPTER II - PART J: CRITICAL CARE COMMITTEE

SECTION 1. COMPOSITION

The Critical Care Committee shall include the Medical Director and Nursing Director of the Hospital's Critical Care Unit and at least two (2) other Members of the Staff who regularly use the Hospital's Critical Care Unit.

SECTION 2. DUTIES

The Critical Care Committee shall:

- A. participate in quality assurance, performance improvement and peer review activities as set forth in the Idaho Code Sections 39-1392-39-1392f; and
- B. develop, implement and maintain a plan for continuous delivery of quality care in the Critical Care Unit of the Hospital. This plan shall provide for development, implementation, and oversight of unit-specific policies and procedures, shall address the admission and discharge of patients to the Critical Care Unit, shall address communications systems as they relate to the Critical Care Unit, shall assure 24-hour in-hospital or on-call coverage of the Unit by the Director or his designee, and shall provide for ongoing performance improvement.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Critical Care Committee shall meet as often as necessary to conduct business, and shall report matters pertaining to performance improvement to the Executive Committee.

CHAPTER II - PART K: SURGICAL SERVICES COMMITTEE

SECTION 1. COMPOSITION

The Committee shall be composed of all Active Staff members of the Departments of Surgery, Anesthesia and OB/GYN, and physicians and staff representing other disciplines that are involved in the provision of surgical services.

SECTION 2. DUTIES

The duties of the Surgical Services Committee shall be:

- A. To report quality assurance, performance improvement and/or peer review activities and refer case reviews, as needed, to Medical Staff Quality Committee, as set forth in the Idaho Code Sections 39-1392 through 39-1392f;
- B. To review issues related to surgical/procedure system issues, both inpatient and outpatient and
- C. Manage block time assignments and utilization.

Recommendations made by the Committee will be forwarded to the appropriate department(s) for action and implementation.

SECTION 3. MEETINGS, REPORTS AND RECOMMENDATIONS

The Surgical Services Committee shall meet as often as necessary to conduct business. It shall maintain a permanent record of its findings, proceedings, recommendations and actions.

CHAPTER II – PART L: SPECIAL COMMITTEES

Special committees shall be created and their members and chairmen shall be appointed by the President as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee

CHAPTER II – PART M: NOMINATING COMMITTEE

SECTION 1. COMPOSITION

The Nominating Committee shall consist of at least three (3) Active Members and the CMO/VPMA. The nominating Committee shall be recommended by the Chief/President of the Medical Staff and appointed by the MEC.

CHAPTER III

CONFLICT OF INTEREST

SECTION 1. PURPOSE AND PHILOSOPHY STATEMENT

The purpose of this Conflict of Interest policy is to help safeguard the integrity as well as the reputation of Saint Alphonus Medical Center – Nampa and its Medical Staff, by fostering the proper and unbiased conduct of Medical Staff activities in the Hospital and all clinics and sites within the Hospital’s organizational structure. In addition, this policy exists to educate the Medical Staff about situations which may generate a conflict of interest and to provide a method of disclosure and managing of conflicts of interest.

SECTION 2. IDENTIFYING AND DEFINING CONFLICTS OF INTEREST

Medical Staff Members must conduct their affairs so as to avoid or minimize conflicts of interest or actions that an independent observer could reasonably perceive as conflicts of interest. When conflicts of interest do arise, Medical Staff members are expected to respond within the guidance provided in this policy.

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

A. The following are representative of conflict of interest situations. The situations presented are meant to provide an idea of common conflict of interest situations; the examples do not represent all circumstances which could be a conflict of interest:

1. Possessing a financial relationship and/or accepting financial benefits from a vendor or service provider of the Hospital, when the Medical Staff member is in a position to determine or influence the Hospital’s purchases from the vendor or service provider.
 - a. A financial relationship is one where the Medical Staff member possesses or receives a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g. stocks, stock options or other ownership interest), food, travel or other personal gain.
 - b. Financial benefits are usually associated with roles such as employment, management, independent contractor positions, consulting, speaking, membership on advisory committees, board membership and other activities from which remuneration is received or expected.
 - c. Financial relationships and financial benefits which are less than \$500 per year are

considered immaterial and are not required to be disclosed unless the Medical Staff member elects to do so.

2. Influence on purchases of equipment, instruments, materials or services for the Hospital from vendors in which the Medical Staff member, or an immediate family member, has a financial interest or receives financial benefit.
 3. Influence upon the negotiation of contracts between the Hospital and private organizations with which the Medical Staff members, or immediate family member, has consulting or other significant relationships, or will receive favorable treatment as a result of such influence.
 4. Improper use of Hospital resources for personal financial gain; and
 5. Transmission to a private entity or individual for personal gain of Hospital- supported work, products, results, materials or other information that is not made generally available to the public.
- B. Medical Staff members shall disclose all material financial interests in writing. A “material financial interest” exists when the Medical Staff member or his or her spouse/domestic partner/child/parent:
1. Has an employment, consulting or other financial arrangement with the Hospital, another Hospital or organization that provides healthcare excluding the physician’s individual or group practice.
 2. Holds an ownership interest of at least 5% in another hospital or organization that provides healthcare excluding the physician’s individual or group practice.
 3. Has any size ownership interest in an organization providing products or services to the Hospital or another hospital (including a financial interest in an entity which is engaged in an existing or proposed business relationship with the Hospital).
 4. Receives more than 5% of his or her annual income from the conflicted financial interest.

SECTION 3. DISCLOSURE

- A. Medical Staff members shall be afforded an opportunity, and have a duty, to disclose in writing, any actual or potential interest that could be reasonable perceived as a conflict of interest, as described above.
- B. Medical Staff members will complete the Medical Staff Conflict of Interest Form at the time of initial application for medical staff membership, as part of the reappointment process and any time any material change in the Medical Staff member’s interests could reasonably be considered a conflict of interest, as described above.
- C. Medical Staff members shall verbally disclose all interests that could potentially constitute or be perceived as a conflict of interest in the course of any Medical Staff meeting where such a disclosure may be relevant to the issues being discussed.
- D. At time of candidacy or prior to appointment, Medical Staff members under consideration for a Medical Staff elected or appointed position shall have a duty to disclose in writing any actual or potential interest that could be reasonably perceived as a conflict of interest, as described above.
- E. If a Medical Staff member is found to have a conflict of interest in relation to a matter that is

under consideration, the Medical Staff member shall abstain from voting and/or recuse himself or herself from discussions or actions pertaining to the matter under consideration; and all written disclosures or other information pertaining to a Medical Staff member or Medical Staff leader will be maintained in the Medical Staff Office.

- F. Consistent with Joint Commission standard LD.04.02.01, this policy and procedure and the conflict of interest disclosed, and any information about the relationship between care, treatment, and services and financial incentives are available upon request to all patients, and those individuals who work for Saint Alphonsus Medical Center Nampa, including staff and licensed independent practitioners.

SECTION 4. PROCEDURE FOR DISCLOSURE AND MANAGEMENT OF CONFLICTS OF INTEREST

A. Disclosure

Whenever a Medical Staff member is in a situation where he or she may potentially be in a conflict of interest, that Member should disclose in writing the details of the situation. The disclosure should be submitted to the President of the Medical Staff and the Chief Executive Officer, or his or her designee. Following this disclosure, the President of the Medical Staff, Officers of the Medical Staff and the Chief Executive Officer, or his or her designee, will gather necessary information from the Medical Staff member and evaluate the situation in an effort to take appropriate action.

B. Conflict of Interest (COI) Management Plan

If the determination is made by the Medical Staff Officers and the Chief Executive Officer, or his or her designee, that a conflict of interest exists, a COI Plan will be created through dialogue and attempted agreement with the Medical Staff member. The COI Plan may include public disclosure of significant financial interest, monitoring of participation in decision-making by Medical Staff leadership as designated; disqualification of the Medical Staff members from participation in all or a portion of certain meetings and/or voting at said meetings; discontinuing the relationship that created the conflict and/or other reasonable measures deemed appropriate by the Officers of the Medical Staff in conjunction with the Chief Executive Officer, or his or her designee. The COI Plan will be kept on file in the Medical Staff Member's Credentials file.

In the event that either the Medical Staff Officers and the Chief Executive Officer, or his or her designee, cannot agree on a COI Plan or the Medical Staff member and the Medical Staff Officers cannot agree on a COI Plan, the matter will be reviewed by the Medical Executive Committee for a recommended COI Plan, subject to Board approval.

If a Medical Staff Officer is the Medical Staff member with the conflict at issue, that Officer shall not participate in the evaluation or decision of how to manage the conflict of interest except to provide his or her input as would any other Medical Staff member.

C. Consequences of Non-Compliance with Policy

If it becomes apparent that a Medical Staff member is not in compliance with the provisions of this policy, whether through failure to disclose a conflict of interest, non-compliance with the COI Plan following disclosure or otherwise, any of the following remedial measures may

be taken as deemed appropriate by the President and President- Elect of the Medical Staff, depending on the nature of the non-compliance:

1. Verbal notification of the Medical Staff member affording him or her an opportunity to address the matter within a specified time frame.
2. Written notification warning, reprimanding and requiring that the Medical Staff member address the matter within a specified time frame.
3. Other remedy deemed appropriate under the circumstances, short of corrective action under the Bylaws; and/or
4. Referral for corrective action under the Bylaws.

Any failure of a Medical Staff member to cooperate in providing material information for consideration under this policy, failure to appear at meetings as requested, failure to abide by the recommended remedial measures under this policy shall be subject to referral for further action as outlined in the “Corrective Action Plan” of the Medical Staff Bylaws.



Saint Alphonsus Health System

CONFLICT OF INTEREST DISCLOSURE FORM

Name: _____ Title: _____

Organization/Department: _____ Contact #: _____

The purpose of this form is for you to disclose any interest or affiliations that you or a family member(s) may have that, when considered in light of your position within or relationship to Saint Alphonsus Health System, hereafter referred to as SAINT ALPHONSUS, as a Medical Staff Member at any Saint Alphonsus facility, and may potentially create a conflict of interest (see examples on following page).

Please disclose your interests and affiliations with Saint Alphonsus Health System in one of the following boxes below:

- I **do not** have any conflicts of interest with **SAINT ALPHONSUS**. Neither do any family members.
- I **do** have a conflict/family member have a conflict *(describe below)***
- I or a family member **may have** a conflict/**not sure** *(describe below)***

Electronic Signature: _____

Date: _____

Please describe the actual or potential conflict of interest below:

***Potential and Actual Conflicts of Interest will be reviewed by the Department Chair/Service Line Leader at your respective hospital(s). The original form, with or without identified conflicts, should be filed in the Medical Staff Member's Credentials File. A copy of all potential or actual conflicts should be sent to the System Integrity Officer.**

POTENTIAL CONFLICTS OF INTEREST

- **IN GENERAL:** Medical staff members may not engage in any personal, business or professional activity which conflicts with the duties and responsibilities of their position within the organization.
- **ENDORSEMENTS AND TESTIMONIALS:** Suppliers, vendors, trade and professional organizations, and others may seek an endorsement or testimonial from medical staff members of **SAINT ALPHONSUS**. Medical staff members cannot agree to perform such endorsements or testimonials without prior written approval from the Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.
- **FINANCIAL INTERESTS:** Except for investments in large, publicly traded companies, medical staff members should disclose financial relationships to **SAINT ALPHONSUS**, medical staff leadership, and patients that could create a risk that professional judgment or actions regarding a primary interest (patient care, research, medical education) will be unduly influenced by personal, family, or friends' gain.
- **MEDICAL STAFF MEMBERS** may not do business with, or on behalf of **SAINT ALPHONSUS**, or recommend that **SAINT ALPHONSUS** do business with a company in which the medical staff member or immediate family member has a financial interest or business relationship without first disclosing such relationship to the Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.
- **If a medical staff's family member works for a vendor, contractor, customer or competitor**, and is in a position to influence the medical staff member's decisions affecting **SAINT ALPHONSUS** with that vendor, contractor, customer or competitor, the medical staff member must **promptly** disclose the family member's position to his/her Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.
- **A conflict of interest may arise when a medical staff member serves as a board member** for an outside organization that does business with or seeks to do business with **SAINT ALPHONSUS**. Public service is encouraged, but such positions must be disclosed to the medical staff member's Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.
- **Unless otherwise directed by SAINT ALPHONSUS**, when speaking on public issues or as a member of an outside organization, medical staff members should not give or permit the appearance that they are speaking on behalf of **SAINT ALPHONSUS**.
- **When serving as a member of an outside organization or in public office**, medical staff members should consider abstaining from any decisions or discussions that could affect **SAINT ALPHONSUS**. The medical staff member should make the reason for abstaining clear to the outside organization or to the applicable public officials and advise his/her Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO about such matter.
- **SELF-DEALING:** Actions disloyal to the organization for personal gain are called "self-dealing" and are prohibited. Examples of self-dealing are stealing, or disclosing proprietary information so that you, a friend, an associate, or a family member may obtain a profit or other advantage.
- **VENDORS and PHARMACEUTICAL INDUSTRY:** Medical staff members are expected to maintain objective relationships with all current and potential health industry and pharmaceutical representatives. Medical staff members must not exert, or appear to exert, special influence on behalf of an industry representative or potential representative because of friendship or any other relationship. Medical staff members must disclose potential conflict of interest/relationships to **SAINT ALPHONSUS**, medical staff leadership, and as applicable to patients who are or may use these products.
- **OUTSIDE EMPLOYMENT:** Employment or medical staff membership with outside entities must not interfere or conflict with the performance of the medical staff member's duties at **SAINT ALPHONSUS**.
- **CONFIDENTIAL INFORMATION:** The use of confidential, non-public information for personal advantage is prohibited.

Photocopies and/ or facsimile copies of this Authorization will serve the same purpose as the originally executed document.

Your electronic signature will be applied upon clicking the "**Submit**" button;

MEDICAL ASSOCIATES AND ADVANCED PRACTICE PROFESSIONALS

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CHAPTER I

MEDICAL ASSOCIATES AND ADVANCED PRACTICE PROFESSIONALS

CHAPTER I - PART A: MEDICAL ASSOCIATES

SECTION 1. QUALIFICATIONS

- A. Medical Associates are appropriately licensed or certified persons practicing a recognized health profession, which generally includes the exercise of independent professional judgment. All Medical Associate categories and privileges must be approved in advance by the Board. Medical Associates do not have admitting privileges and shall provide inpatient services only as consultants to an admitting physician. The current approved Medical Associate categories are:
- Clinical Psychologists
 - Consulting Dermatologist
- B. Every individual who applies to become a Medical Associate must meet the Qualifications and will be subject to the provisions of Article I, Part A, Section 2, a, c – i, Section 3 through Section 9 of these Bylaws.
- C. Each applicant for Medical Associate status shall file an application on a form provided by the Hospital. Each applicant shall be evaluated by the appropriate Medical Staff department chairman and the Credentials Committee, which shall recommend to the Executive Committee of the Medical Staff, which shall recommend to the Board of Directors the privileges that the applicant shall be permitted to exercise in the Hospital. The final determination of the applicant's privileges shall be made by the Board. The determination of the Board shall be final with no right of appeal except as set forth in Chapter IV Part C of this Medical Associates & APP's document.
- D. Medical Associates may only engage in activities within the privileges specifically granted by the Board.
- E. If qualified and approved by licensing board for prescriptive authority a supervising physician, member of the medical staff, must be appointed to supervise and verify all supervising criteria mandated by licensing board.
- F. Medical Associates are not members of the Medical Staff and do not enjoy the prerogatives of Medical Staff membership.

CHAPTER I - PART B: ADVANCED PRACTICE PROFESSIONALS

SECTION 1. GENERAL

- A. Advanced Practice Professionals (APPs) are appropriately licensed persons practicing a recognized health profession which generally includes the exercise of independent professional judgment under the collaboration or sponsorship of an employer or contracting physician. All APP categories and privileges must be approved, in advance,

by the Credentials Committee, the Executive Committee of the Medical Staff and the Board of Directors.

B. The current approved Advanced Practice Professional categories are:

1. Sponsored Advanced Practice Professionals, which include:

- a. Certified Nurse Midwives
- b. Certified Nurse Anesthetists

2. Collaborating Advanced Practice Professionals, which include: -

- a. Nurse Practitioners
- b. Physician Assistants
- c. Clinical Nurse Specialists

J. Any additional categories approved pursuant to section 1A above will be maintained in the Medical Staff Office.

K. APPs are not members of the Medical Staff and do not enjoy the prerogatives of Medical Staff membership.

SECTION 2. QUALIFICATIONS, APPLICATIONS OR PRIVILEGES

The qualifications, application or privileges of APPs will be governed by the Medical Staff Policy for Granting Privileges to Advanced Practice Professionals Ineligible for Medical Staff Membership.

CHAPTER II

APP POLICY & PROCEDURE

CHAPTER II - PART A: ADVANCED PRACTICE PROFESSIONAL POLICY

SECTION 1. POLICY INFORMATION

Various physician specialties require support from Advanced Practice Professionals (APPs) who are not employed by the Hospital and may be directly employed by a physician, physician group, or contracted with a physician group. APPs who are employed by the Hospital are credentialed through human resources. APPs who are independent are processed through the Medical Staff Services Credentialing process which is equivalent to Human Resources process.

The following types of APPs may be granted permission to provide patient care services at Saint Alphonsus Medical - Nampa:

- Dental Assistants
- Non-Physician Surgical First Assistants
- Oral Surgery Assistants
- Scribes
- Surgical Technicians

APPs are not members of the Medical Staff and do not enjoy the prerogatives of Medical Staff membership. As such, they are not entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff.

SECTION 2. QUALIFICATIONS

Advanced Practice Professionals must be qualified by academic and clinical or other training to practice in a clinical or supportive role and may provide services only under the supervision of Medical Staff physicians with clinical privileges at the Hospital. In addition, APPs may provide services only when recommended by his or her employer or contracting physician, as permitted by this Hospital and in keeping with all applicable laws, regulations, rules, policy and plans, and procedures and protocols.

To be permitted to perform services, an applicant must:

- A. Be a graduate of an accredited school or have completed a requisite course of study and training in his or her discipline;
- B. Be legally qualified to practice in the given discipline in this state;
- C. Have demonstrated clinical competence in his or her discipline;
- D. Meet the specific qualifications and requirements established by the Hospital;
- E. Meet any malpractice insurance conditions established by the Hospital; and
- F. Not be excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

SECTION 3. EXPECTATIONS

Advanced Practice Professionals are expected to:

- A. Complete orientation;
- B. Protect patients by adhering to Infection Prevention policies of the Hospital including annual influenza vaccination;
- C. Comply with the Hospital's Customer Services Standards and Standards of Conduct including interpersonal communication and professional conduct expectations;
- D. Demonstrate compliance with all relevant Hospital and departmental policies and procedures, including those related to:
 - 1. Ethical and Religious Directives
 - 2. Drug and Alcohol Free Workplace;
 - 3. Safety and Environment of Care;
 - 4. Immunization (as required by their collaborating physician)
 - 5. Dress Code; and
 - 6. Name Badge.
- E. Understand the means of accomplishing the essential functions of the job outlined on the job description
- F. Maintain a criminal history free of material concerns

CHAPTER II - PART B: ADVANCED PRACTICE PROFESSIONAL PROCEDURE

SECTION 1. APPLICATION

Each applicant must complete an application form(s) supplied by the Hospital and deliver it to Medical Staff Services. Applications must be accompanied by:

- A. Application fee;
- B. Authorization for release of information;
- C. Confidentiality and network access agreement;
- D. Completed job description;
- E. Proof of liability insurance;
- F. Proof of Immunizations and/or health screening tests that are also required for their collaborating physician;
- G. Collaborative Physician Agreement completed and signed by the APP and the collaborating physician;
- H. Completed orientation acknowledgement.

SECTION 2. VERIFICATION

Medical Staff Services will seek to conduct primary source verification of information contained within the application (when applicable) and will seek to collect additional information as is deemed necessary to permit an adequate and complete evaluation of the individual's request for permission to provide services. Verification will include:

- A. Primary source verification of licensure, certification and/or registration (as applicable to the licensure), employment history and peer references;
- B. Verification of identity by current driver's license with photo, passport or other photo I.D;

- C. Office of Inspector General screening;
- D. Criminal Background Check.

Once the application is determined to be complete, Medical Staff Services will notify applicable Hospital director(s).

SECTION 3. EVALUATION AND REPORTING

Practice prerogatives are extended to APPs subject to annual competency review, including collaborating physician and department director competency evaluations. Failure to successfully complete an annual competency review is grounds for termination of practice prerogatives.

A report will be submitted to the Medical Executive Committee and Board annually concerning the identity, scope of practice, collaborating physician and competency of Medical Assistants who have been reviewed and approved according to this policy.

CHAPTER III

FPPE AND OPPE PROCESS

SECTION 1. PURPOSE/SCOPE

The purpose of this process is to monitor performance/competency of Advanced Practice Professionals in order to measure and continually improve performance and provide ongoing assessment in a measurable way.

SECTION 2. BACKGROUND

Physician Assistants, Certified Nurse Anesthetists, Clinical Nurse Specialists and Nurse Practitioners are Advanced Practice Professionals at Saint Alphonsus Medical Group and do not function independently by Hospital Policy. Physician collaboration is outlined in the collaborating physician agreement on file in the Medical Staff Office.

SECTION 3. GUIDELINES

- A. Focused Professional Practice Evaluation (FPPE) during the provisional period will occur as follows:
 - 1. Five Cases will be reviewed each quarter and the results reported to the Department Chair;
 - 2. Department Chair will be notified of any adverse findings;
 - 3. At the end of the provisional period reports will be compiled and aggregate information will be reported to the Department Chair, Credentials Committee, Medical Executive Committee and the Board of Directors.
- B. Ongoing Professional Practice Evaluation (OPPE)
After the provisional period, ongoing evaluation will occur as follows:
 - 1. Cases are screened for peer review indicators. If a finding is attributed to the Advanced Practice Professional, the case will be reviewed and tracked through the peer review system and reported at the time of reappointment;
 - 2. At the end of each reappointment period, the collaborating Physician or Department Director(s) will be asked to provide an evaluation.
 - 3. The Medical Staff Office will aggregate the information and report to the Department Chair who will make a recommendation for reappointment to the Credentials Committee, Medical Executive Committee and the Board of Directors.

CHAPTER IV

PROCEDURAL REVIEW RIGHTS OF MEDICAL ASSOCIATES AND ADVANCED PRACTICE PROFESSIONALS

SECTION 1. RESTRICTION, SUSPENSION, OR TERMINATION

A. Overview

The Executive Committee, President or Chief Executive Officer may, at any time, order the restriction, suspension, or termination of the privileges or status of any Medical Associate or Advanced Practice Professional (APP), with or without cause. If feasible, the person or body so doing shall consult the Department chairperson and any collaborating or sponsoring physician of the APP prior to taking action.

B. Grounds for Procedural Review Rights

Any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for procedural review rights:

1. Denial of Medical Associate or Advanced Practice Professional appointment and/or reappointment;
2. Revocation, suspension, restriction and/or involuntary reduction of Medical Associate or Advanced Practice Professional appointment and/or privileges; and
3. Precautionary suspension of Medical Associate or Advanced Practice Professional appointment and/or privileges;

C. Procedural Rights

Nothing contained in these Bylaws shall be interpreted to entitle a Medical Associate or an APP to the procedural rights set forth in any other article of these bylaws.

Any Medical Associate or APP, however, shall have the right to challenge any action that would constitute grounds for procedural rights under Chapter IV, Section 1 B. by filing a written grievance with the Executive Committee within fifteen (15) days of such action. On receipt of such a grievance, the Executive Committee or its designee shall conduct an investigation that shall afford the practitioner an opportunity for an interview concerning the grievance. Any such interview shall not constitute a “hearing,” as that term is defined in the Fair Hearing Process and the procedural rules applicable to such hearings shall not apply. Before the interview, the practitioner shall be informed of the general nature and circumstances giving rise to the action, and the practitioner may present information relevant thereto at the interview. A record of the interview shall be made. The collaborating or sponsoring physician, if any, of the practitioner may participate in the interview. The Executive Committee, or its designee, shall make a decision based on the interview and all other information available to it.

SECTION 2. AUTOMATIC TERMINATION

The privileges of a Medical Associate or Advanced Practice Professional shall automatically

terminate, without right to procedural review, in the event:

- A. The Medical Staff membership of all collaborating or sponsoring physician(s) of the APP is suspended, terminated, or restricted, whether voluntarily or involuntarily;
- B. The APP's collaborating or sponsoring physician(s) no longer agree(s) to act as a collaborator or sponsor for any reason, or the relationship between the APP and the collaborating or sponsoring physician(s), if any, is otherwise terminated, regardless of the reason;
- C. A contractual, employment, or other relationship between the Hospital and one or more APPs in the affected category limits the number of APPs in that category who may practice at the Hospital;
- D. The Medical Associate or APP license or certificate to practice expires, is revoked, suspended, or otherwise restricted; or
- E. The Medical Associate or APP is excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid;

SECTION 3. REVIEW OF CATEGORY DECISION

The procedural rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for privileges at the Hospital. Questions regarding such decisions shall be submitted to the Board, which has the discretion to decline to review the request, or to review it using any procedure it deems appropriate.

CHAPTER V

MEDICAL STAFF POLICY FOR GRANTING PRIVILEGES TO ADVANCED PRACTICE PROFESSIONALS INELIGIBLE FOR MEDICAL STAFF MEMBERSHIP

SECTION 1. DEFINITIONS

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

SECTION 2. GENERAL INFORMATION

The Board permits certain types of Advanced Practice Professionals (APPs) who have not been appointed to the Medical Staff to provide patient care services. Such practitioners must be qualified by academic and clinical or other training to practice in a clinical or supportive role. APPs may provide services only under the supervision of Medical Staff physicians with clinical privileges at Saint Alphonsus Medical Group. In addition, APPs may provide services only as permitted by this Hospital and in keeping with all applicable laws, regulations, rules, policy and plans, and procedures and protocols including, but not limited to, applicable portions of the Medical Staff Bylaws.

APPs are not members of the Medical Staff and do not enjoy the prerogatives of Medical Staff membership. As such, they are not entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff.

The number of APPs under the collaboration of one physician or sponsorship of one physician or group, as well as the acts they may undertake, shall be consistent with applicable federal and state statutes and regulations, the policy and plans of the Medical Staff and the policies of the Hospital

SECTION 3. ADVANCED PRACTICE PRACTITIONERS

The following types of APPs may be granted permission to provide patient care services at Saint Alphonsus Medical Center:

- A. Sponsor: is a designated physician member of the Medical Staff who is responsible for entering into a collaborative relationship with the APP. Advanced Practice Professionals must be employed by a physician/group with permanent privileges on the Active Staff of Saint Alphonsus Medical Group who is/are willing and able to provide collaboration in patient management, provide consultations and accept referral of patients as delineated in the privileges approved by the Board. These practitioners that have a sponsored physician include:
1. Certified Nurse Midwives
 2. Certified Nurse Anesthetists

B. Collaboration: is the process whereby an APP and physician jointly manage the care of a patient, which has become complicated. The scope of collaboration may encompass the physician's care of the patient, including a mutually agreed upon plan of care.

When the physician must assume a dominant role in the care of the patient due to increased risk status, the APP may continue to participate in physical care of the patient. Effective communication between the APP and Physician is essential for ongoing collaborative management. Advanced Practice Professionals must be employed by, or contracted with, and collaborated by a member or members of the Medical Staff as delineated in the clinical privileges approved by the Board.

1. Nurse Practitioners
2. Physician Assistants
3. Clinical Nurse Specialists

C. Any additional categories approved pursuant to Chapter I, Part B, Section 1A of this Medical Associates and APP's document. A list of all approved categories will be maintained in the Medical Staff Office.

SECTION 4. QUALIFICATIONS

To be permitted to perform services, an applicant must:

- A. be a graduate of an accredited school;
- B. be legally qualified to practice in the given discipline in this state;
- C. have demonstrated clinical competence in his or her discipline;
- D. meet the specific qualifications and requirements established by the Hospital;
- E. meet any malpractice insurance conditions established by the Hospital;
- F. where appropriate, hold current, valid federal and state narcotics certificates; and
- G. not be excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

Practitioners who are employed by, or under contract with a Medical Staff member with clinical privileges at Saint Alphonus Medical Center Group may be given permission to provide services only when recommended by his or her employer or contracting physician.

Collaborating or sponsoring physicians must be personally qualified and must be currently credentialed to provide the services and to perform the procedures being requested on behalf of the APPs.

SECTION 5. APPLICATIONS

- A. Each Advanced Practice Professional applicant must complete application form(s) as indicated below:
 1. Each applicant for the Advanced Practice Professional status shall submit a fully completed application and signed collaborating physician agreement form from each collaborating physician, sponsoring physician or group provided by the Hospital. Applications of Advanced Practice Professionals will be processed in the same manner as applications for Medical Staff Members as described by current medical staff bylaws, policies and procedures.
 2. Each applicant shall be evaluated by the appropriate Medical Staff department chairperson

and the Credentials Committee, which shall recommend to the Executive Committee of the Medical Staff, which shall recommend to the Board of Directors the privileges which the applicant shall be permitted to exercise in the Hospital. The final determination of the applicant's privileges shall be made by the Board. The determination of the Board shall be final with no right of appeal except as set forth in Chapter IV of this Medical Associate & APP's document.

3. Reappointment of Advanced Practice Professionals will be handled in the same manner as reappointments for Medical Staff Members as described by current medical staff bylaws, policies and procedures.

B. Applications must be accompanied by:

1. A written statement signed by the applicant's employer supporting the request for permission to provide services and confirming that the applicant is currently employed by or under contract with the medical staff member or their employer;
2. A written agreement by the collaborating physician, sponsoring physician, or group, as appropriate, for the privileges requested, to:
 - a. Assume responsibility for collaboration, sponsorship or monitoring of the applicant;
 - b. Be available, or provide an alternate to be available, for consultation when requested, and to intervene when necessary;
 - c. Assume responsibility for the care of any patient, when requested by the applicant, or required by policy, or in the interest of patient care; and
 - d. Sponsored or Collaborating Physicians or their designee are required to co-sign all history and physicals and discharge summaries and should co-sign all orders and records as necessary.

SECTION 6. TERM AND REVIEW OF PRIVILEGES

- A. Initial privileges shall be extended to Advanced Practice Professionals who have either a sponsoring or collaborating physician for a provisional period of twelve (12) months from the date they are granted or longer (for a period not to exceed one (1) additional year) if recommended by Credentials Committee. Continued privileges after the provisional period shall be for a period not to exceed 24 months and shall be conditioned on an evaluation of the applicable factors to be considered for continued privileges as determined by the medical staff and hospital.
- B. Each Advanced Practice Professional's application for continued privileges shall be evaluated by the appropriate Medical Staff department chairperson and the Credentials Committee, which shall recommend to the Executive Committee of the Medical Staff, which shall recommend to the Board of Directors the privileges, if any, the applicant shall continue to be permitted to exercise in the Hospital. This final determination shall be made by the Board and shall be final with no right of appeal except as set forth in Chapter IV of this Medical Associate & APP's document.
- C. Each Advanced Practice Professional agrees to participate in quality assurance, performance improvement and peer review activities. The quality of care provided by each Advanced Practice Professional will be reviewed on an ongoing basis as set forth in the Advanced Practice Professional Performance Feedback Process Policy. Any concerns will be referred to an appropriate Medical Staff Department/Committee for review and follow-up.

SECTION 7. PROFESSIONAL ETHICS

All APPs providing services in the Hospital shall be governed by the principles of professional ethics established by both their profession and the law and shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops. No activity prohibited by said Directives shall be engaged in by any APPs providing services in the Hospital.

SECTION 8. ADHERENCE TO CORPORATE RESPONSIBILITY PROGRAM

All APPs shall abide by the Corporate Responsibility Program, including, without limitation, the Trinity Standards of Conduct and any related education and training requirements.