MEDICAL STAFF BYLAWS
AND
RULES & REGULATIONS

Holy Rosary Healthcare

MILES CITY, MONTANA

October 2012
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PREAMBLE

Recognizing that the best interests of the patient are protected by concerted effort, the physicians practicing in Holy Rosary Healthcare hereby organize themselves in conformity with the Bylaws, Rules and Regulations of the Medical Staff, and in accordance with the Bylaws of Holy Rosary Healthcare.

ARTICLE I

DEFINITIONS

Administration - Whenever the term Administration appears, it shall be interpreted to refer to personnel in charge of the day-to-day management of Holy Rosary Healthcare.

Administrator - Whenever the term Administrator appears, it shall be interpreted to refer to the CEO/Administrator of Holy Rosary Healthcare.

Allied Health Professionals - means and refers to those classes of health care professionals, other than Physicians Dentists, and Podiatrists, whose skills and knowledge have been determined by the Board of Directors to be needed for the care of patients in the Hospital, who have been licensed or certified by their respective licensing or certifying agencies to provide such care or who provide limited care as Medical Assistants or registered nurses under the direct supervision of Members of the Medical Staff and who may be granted, on an individual basis, limited clinical privileges by the Board of Directors. Allied Health Professionals include employees of the Hospital, if an Advanced Practice Registered Nurse, a Physician Assistant and independent health care providers. Examples of Allied Health Professionals are Advanced Practice Registered Nurses, Psychologists, Physician Assistants, technologists, therapists, Medical Assistants. Nurses and other healthcare providers (except Advanced Practice Registered Nurses, Physician Assistants, Psychologists and those eligible for Medical Staff appointment) provided under contract to the Hospital by staffing agencies shall be treated as employees of the Hospital and credentialed through the Hospital's human resources department or other internal mechanisms.

Board - Whenever the term Board appears, it shall be interpreted to refer to the Board of Directors governing body of Holy Rosary Healthcare.

Clinical Privileges or privileges - means the permission granted by the Board of Directors to a Practitioner (or, as applicable, to an Allied Health Professional) to render care or perform specific diagnostic, therapeutic, medical, dental or surgical procedures in the Hospital pursuant to the Appointment Policy.

Ex Officio - When the term Ex Officio appears it shall be interpreted to refer to attendance and without vote.

He - The term He shall represent both the masculine and the feminine sex.

Medical Executive Committee (MEC) - Whenever the term MEC appears, it shall be interpreted to refer to the Executive Committee of the Medical Staff in accordance with Article IV, Section 2, Subsection A.

Medical Staff - For the purpose of these Bylaws, the words "Medical Staff" shall be interpreted to include all physicians, duly appointed to the Medical Staff in accordance with Article III, who are privileged to admit and attend patients in Holy Rosary Healthcare.

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Practitioner - Whenever the term practitioner appears, it shall be interpreted as an individual licensed by the state of Montana to engage in the practice of medicine, osteopathy, podiatry, optometry, or a nursing specialty (advanced practice registered nurse licensed by the state of Montana recognized by the board of nursing as a nurse practitioner or a clinical nurse specialist) or licensed as a physician assistant-certified (a physician assistant-certified licensed by the state of Montana).

Patient - Whenever the term Patient appears, it shall be interpreted to refer to any person receiving medical services from Holy Rosary.

Credentialing - means the process of obtaining and verifying information provided by applicants for appointment and/or clinical privileges or from third party sources concerning the applicant’s status, satisfaction of basic requirements of education, training, licensing or certification, insurance, any required affiliations or associations and similar information to determine whether threshold requirements have been met for the Medical Staff and Board of Directors’ use in determining whether to grant appointment to the Medical Staff and/or grant clinical privileges.

Roberts Rules - The rules of order for these Bylaws shall be Roberts Rules of Order.

ARTICLE II
PURPOSE

The purpose of this organization shall be:

1. To strive that all patients admitted to the Healthcare or treated in the outpatient areas receive the best possible health care as per the Quality Improvement Plan at Holy Rosary Healthcare regardless of race, color, sex, creed or national origin.
2. To provide a means whereby the Medical Staff with the Board and the Administration may discuss problems of a medico-administrative nature.
3. To initiate and maintain effective self-government.
4. To promote educational programs and standards.
5. To function as staff as a whole with Holy Rosary Healthcare operating as a non-departmentalized Healthcare.
6. To provide appropriate diagnostic, therapeutic, rehabilitative and other services to meet the needs of the patient population. Services are provided directly or through appropriate referral, consultation, contractual or other arrangements.

ARTICLE III
MEMBERSHIP

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements applicable to the category of the Medical Staff to which appointment has been granted or is sought in accordance with the medical staff credentialing criteria or policies as are adopted from time to time by the Board of Directors. The Bylaws, the Rules and Regulations, Medical Staff Policies and Procedures and credentialing criteria are intended to be dynamic and evolving as medical science and the standards of the Hospital, Medical Staff and operations of the Hospital change from time to time. All individuals practicing medicine, dentistry or podiatry in the Hospital, unless accepted by specific provisions of these Bylaws must first have been appointed to the Medical Staff. The specific qualifications for appointment and

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reappointment and granting of clinical privileges in general shall be established by the MEC and approve by the Board of Directors and be amended to reflect the current standards and practices.

SECTION 1. Qualifications

Subsection A. The applicant for membership must be qualified legally, professionally and ethically and be competent with good physical and mental health for the staff position to which appointed. Other membership criteria would include:

1. A currently valid unrestricted license issued by the State of Montana to practice medicine, dentistry, osteopathy, or podiatry.
2. have a record that is free from current Medicare/Medicaid/TriCare sanctions by not being identified on the OIG list of excluded individual/entities;
3. have a record that is free of felony convictions within the last three years or occurrences that would raise questions of undesirable conduct which would injure the reputation of the medical staff or hospital;
4. Demonstrate appropriate written, vocal and computer skills.
5. Demonstrate recent clinical performance within the last 12 months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria.
6. Provide verification of current and adequate professional liability insurance in accordance with the limits established within these Bylaws, Rules and Regulations, a history of malpractice claims filed, a current status of these claims, and a listing of privileges at other facilities together with any pending disciplinary actions.
7. Meet all credentialing requirements established in accordance with the rules and regulations promulgated by the Medical Staff of Holy Rosary Healthcare.
8. In the event a staff member loses licensure status, such member shall automatically be deprived of staff membership and privileges, without prior notice.
9. when the MEC or the Board has reason to question the physical and/or mental health status of a practitioner, he shall be required to have an evaluation of his physical and/or mental health status by a physician or physicians acceptable to the Medical MEC or the Board, as a prerequisite to further consideration of his application for appointment or reappointment, to the exercise of previously granted privileges, or to the maintenance of his Medical Staff appointment.
10. Provide a valid email address that will be used as a primary method of communication.

Subsection B. Neither religion, handicap, sex, color, race, age, creed nor national origin shall disqualify the applicant.

SECTION 2. Responsibilities of Staff Membership

Each member of the Medical Staff shall:

1. Provide his patients with care at the generally recognized professional level of quality and efficiency.
2. Abide by the Medical Staff Bylaws, Rules and Regulations, TJC Standards, policies and standards of the Healthcare.
3. Discharge staff, committee, and Healthcare functions for which he is responsible by staff category assignment, appointment, and election or otherwise.
4. Prepare and complete in timely fashion the medical and other required records for all patients he admits or in any way provides care to in the Healthcare.

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5. Participate in Healthcare peer review activities, Quality/performance Improvement programs, Utilization Review, TJC survey, and any regulatory agencies.

6. Promptly notify the Administrator of the Healthcare of the revocation or suspension of his professional license, or of the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Montana, or of the filing of a claim against the practitioner for alleged professional liability.

7. Provide evidence of appropriate liability coverage.

8. Use confidential information only as required for treatment of patients or carrying out peer review activities in accordance with HIPAA regulations.

9. Participate in electronic medical record training and seek additional training as needed to effectively utilize the electronic medical record.

10. When available, immediately utilize the electronic medical record for electronic chart review and for electronically documenting notes. Note: Hospital staff will not be expected to print any part of the chart for the purpose of chart review.

11. Actively use the electronic problem list (as soon as available) as a key communication tool for enhanced reporting and performance optimization.

12. When available and when in the facility, medical staff will utilize Computerized Physician Order Entry (CPOE) with electronic medication reconciliation. Utilize paper processes for medication reconciliation and ordering until electronic methods are available.

SECTION 3. Ethics and Ethical Relationship

The code of ethics as adopted by the American Medical Association and American Osteopathic Association shall govern the professional conduct of the Medical Staff of Holy Rosary Healthcare. In addition, the Hospital is a member of Sisters of Charity of Leavenworth Health System, Inc., and as such follows the Ethical and Religious Directives for Catholic Healthcare Services (2001) as revised from time to time by the National Conference of Catholic Bishops, approved by the National Conference of Catholic Bishops and promulgated by the Diocese of Great Falls/Billings, Montana (the “Ethical Religious Directives”). All Practitioners and Allied Health Professionals practicing within the Hospital are expected to and must agree to conform with and abide by such Ethical Religious Directives in the care and treatment of all patients for whom they may provide care, treatment, or consultation. Each applicant to the Medical Staff and each applicant for Clinical Privileges shall be provided with a copy of such Ethical Religious Directives and shall be expected to include with any application for appointment or reappointment to the Medical Staff or for Clinical Privileges.

Subsection A. Communication. Except as otherwise ordered by the Chairman of the Board of Directors, communications between Directors and members or aspirants to the staff shall be confidential in respect to appointment to the staff and disciplinary action by the Board with respect to any member of the staff. Breach hereof shall be construed as unethical conduct. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such allegations or incidents to appropriate regulatory agencies, insurers, or Healthcare administration.

SECTION 4. Application for Membership

Subsection A. Application for membership on the Medical Staff shall be presented in writing on the prescribed application form which shall state the applicant’s qualifications and references of three persons who have had sufficient experience in observing and working with the applicant to enable them to render an opinion on his professional competence and who can provide adequate information
pertaining to the applicant’s professional competence and ethical character. Information shall be presented as to whether the applicant's membership status and/or clinical privileges are pending or have ever been voluntarily or involuntarily revoked, suspended, reduced, or renewed at any other health care institution, and information as to whether his membership in local, state, or national medical societies, or his registration or license to practice any profession in any jurisdiction has ever been voluntarily or involuntarily suspended or terminated. In accordance with TJC Medical Staff Standards, a recent photo identification of the applicant to verify identity such as driver’s license, passport, or visa if not a citizen of the United States is required. A completed application is defined as when all the questions on the application have been determined to have been answered satisfactorily and information requested has been submitted adequately. Such applications shall be processed for verification by the Medical Staff Office. Any incomplete applications will not be processed and will not be grounds for a fair hearing.

Subsection B. He shall signify his agreement to abide by the Bylaws and Rules and Regulations of the Medical Staff of Holy Rosary Healthcare and the Bylaws of Holy Rosary Healthcare. Every individual, by filing an application for appointment or reappointment to the MEC or for clinical privileges at Holy Rosary Healthcare, consents and shall sign all necessary documents to allow to Medical Staff and Healthcare representatives inspecting all records and documents that may be material to an evaluation of his professional qualifications and competence, physical and/or mental health status and his professional ethical qualifications. This includes but is not limited to a query of the National Practitioner Data Bank. Authorization is further deemed to be given to consult with others who have associated with the applicant to obtain information bearing on the applicant's competence and qualifications.

Subsection C. Each applicant hereby releases from any liability all individuals and organizations who provide information and further releases all Healthcare and Medical Staff representatives who act in good faith and without malice concerning their investigation and review of the applicant's competence, professional ethics, character, physical and/or mental health, emotional stability and other qualifications for staff appointment and clinical privileges.

Subsection D. Each initial application for MEC appointment must contain a request for the specific privileges desired by the applicant. The initial determination as to privileges shall be based upon the applicant's education and training, demonstrated competence, references, and other such information as may be deemed pertinent and shall include an appraisal by physicians on Holy Rosary Healthcare's Medical Staff.

Subsection E. The applicant shall have the burden of producing adequate information for a proper evaluation of his experience, professional ethics, background, training, demonstrated ability, and, upon request of the MEC or of the Board, physical and/or mental health status, and for resolving any doubts about these or any of the other basic qualifications.

Subsection F. Any further investigation of these application materials shall be conducted or coordinated by the office of the Administrator of the Healthcare as directed by the Credentials Committee of the MEC. If additional information is required of the applicant, the Administrator will request it in writing. Applicant is to provide such requested information within thirty (30) days of the receipt of the request.

SECTION 5. Procedure for Initial Appointment

Subsection A. The “completed application” for membership on the Medical Staff shall be presented to the Medical Staff Office or the Administrator of the Healthcare to be processed for verification. The scope

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Subsection B. At the first Medical Executive Committee meeting thereafter the Credentials Committee shall present its report to the MEC along with its recommendations concerning the application.

Subsection C. In no case shall this report of the Credentials Committee recommending that the application be accepted, deferred, or rejected be delayed for more than sixty (60) days.

Subsection D. On receipt of the report of the Credentials Committee the MEC shall recommend to the Board, at the Board's next meeting, that the application be accepted, deferred, or rejected.

Subsection E. The Board shall either accept the recommendation of the MEC or shall refer it back for further consideration in no less than ten (10) days after the Board's meeting. In the latter case, the Board shall instruct its secretary to state in writing the reasons for such action to the MEC.

Subsection F. When final action as to acceptance or rejection of the application has been taken by the Board, the Administrator of the Healthcare shall transmit this decision to the candidate for membership within one (1) week by letter.

Subsection H. A separate credentials file will be provided for each applicant and every Medical Staff member. The credentials file(s) are to be held in strict confidence and released only upon request of the individual staff member, court order, peer review committee or other regulatory agencies or hospital administration.

Subsection I. An applicant whose appointment received adverse recommendation by the Board shall have the right of a hearing under provisions in SECTION 8 of this Article - Hearing and Appeal Procedure.

Subsection J. Recommendation for initial delineation of privileges of newly appointed physicians shall be based on the findings of the Credentials Committee and MEC.

Subsection K. A term of appointment or reappointment shall cease:
1. When a term of appointment and reappointment exceeds 24 months.
2. Upon the Board accepting formal notice of resignation of appointment;
3. Upon the Board giving notice of cancellation of appointment;
4. According to the terms of notice of suspensions of appointment as given by the Board;
5. Upon the loss of Montana Medical, Dental or Podiatrist license;

SECTION 6. Determination of Clinical Privileges

Every Medical Staff member or Allied Health Professional providing direct clinical services at the Healthcare by virtue of Medical Staff membership or otherwise shall, in connection with such practice be entitled to exercise only those clinical privileges or provide patient care services as are specifically granted pursuant to the provisions of these Bylaws, Rules and Regulations.

All Medical Staff members granted clinical privileges shall be subject to the provisions of exclusivity as may be adopted by the Board. Any adverse recommendation or action respecting clinical privileges based on the provisions of exclusivity shall not give rise to any right to a hearing or appellate review provided in these Bylaws, including those provided in SECTION 8 of this Article.

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Subsection A. Delineation of Privileges in General - Each application for appointment and reappointment to the Medical Staff must contain a request for the clinical privileges desired by the applicant. A request by a Medical Staff member pursuant to SECTION 7, SUBSECTION B of this Article for modification of privileges must be supported by documentation of training and/or experience supportive of the request.

Subsection B. Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgment. The basis for privilege determinations will be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the quality/utilization management activities required by these Bylaws and the Healthcare's Bylaws. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources including, but not limited to, other health care institutions where a practitioner exercises clinical privileges. This information shall be added to and maintained in the file established for each Medical Staff member.

Subsection C. Temporary Privileges

Temporary Privileges are available to Practitioners who have filed appropriate completed applications under two circumstances:

a. Temporary Privileges for a new applicant may be granted when the applicant's file is complete and awaiting review and approval by the organized medical staff upon verification of criteria defined in these bylaws.

b. To fill an important patient care need, on a case by case basis and are limited to the time of treatment until the patient is discharge from care and are subject to the further qualifications set forth in these bylaws and medical staff rules and regulations.

Upon recommendation of the President of the Medical Staff or appointed designee by the President of the HRH medical staff and the Administrator of the Healthcare, or appointed designee by the administrator of HRH may grant temporary privileges to a physician for a period of four (4) weeks, if necessary, temporary privilege extensions may be renewed for successive four (4) week periods not to exceed 120 days, provided that such physician seeking temporary privileges meets the qualifications set forth in these Bylaws and bears the affirmative burden of establishing that he or she:

c. Is duly licensed to practice in the State of Montana;

d. Has professional liability insurance, as specified by the Board of Directors pursuant to these Bylaws, covering exercise of the privileges requested; and

e. Possesses, based upon information reasonably available under the circumstances, the relevant training or experience, qualifications, current competence, abilities and judgment necessary to exercise the requested privileges.

f. A query and evaluation of the NPDB Information.

h. Any temporary privileges granted under this Subsection shall be delineated as to the scope of such privileges for each respective physician.

Granting of the temporary privileges does not ensure an award of Medical Staff Membership or regular clinical privileges. The President of Medical Staff may impose consultation, monitoring, or reporting requirements as part of his FPPE.

The Administrator of Holy Rosary Healthcare or Holy Rosary Healthcare administrator designee may, upon consultation with the President of Medical Staff or Holy Rosary Healthcare president of the medical staff, deny, modify or terminate temporary privileges. Such actions, unless otherwise described, are deemed not to relate to the applicant's or holder's professional competence or conduct and do not entitle him/her to a October 2012
hearing under the Fair Hearing Procedure. Grounds not entitling a practitioner to a hearing may include:
   i. the applicant’s failure to bear the burden of providing sufficient information regarding his licensure, insurance or competence;
   j. The information reasonably available is insufficient under the circumstances to allow or continue to allow the practitioner to exercise the requested privileges.
   k. Criteria for disqualification would include but no limited to involuntary relinquishments of license, privileges and memberships at other hospitals.

SECTION 7. Professional Practice Evaluation

The medical staff will engage in ongoing professional practice evaluation (OPPE) in order to identify professional practice trends that impact on quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. The OPPE shall be undertaken as part of the medical staff’s quality improvement activities. In addition, each practitioner may be subject to a focused professional practice evaluation (FPPE) when issues affecting the provision of safe, high quality patient care are identified. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual’s current clinical competence, practice behavior, and ability to perform a specific privilege. In addition, all initially requested privileges shall be subject to the FPPE (See Medical Staff Policy & Procedures). The credentials committee and with the approval of the MEC will define circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital (Refer in Medical Staff Policy & Procedures). Such monitoring may utilize a range of techniques, including but not limited to: chart review, the tracking of performance monitors/indicators, proctoring, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The credentials committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring. Newly appointed physicians as Associate Medical Staff members and physicians granted temporary privileges shall have their performance and clinical competence observed by the President of the Medical Staff or his designee.

SECTION 8. Terms for Reappointment

Subsection A. The Administrator of the Healthcare shall, at least ninety (90) days prior to the expiration date of the present staff appointment of each Medical Staff member, provide such staff member with reappointment forms prescribed by the Board for use in considering reappointment. The reappointment forms shall include evidence of a current license in the State of Montana, and verification of professional liability insurance. Information shall be presented as to whether the applicant’s membership status and/or clinical privileges are pending or have ever been voluntarily or involuntarily revoked, suspended, reduced, or renewed at any other health care institution, and information as to whether his membership in local, state, or national medical societies, or his registration or license to practice any profession in any jurisdiction has ever been voluntarily or involuntarily suspended or terminated. Each Medical Staff member who desires reappointment shall, within thirty (30) days of receipt of the reappointment forms return the forms to the Administrator. Failure, without good cause, to so return the forms shall constitute a voluntary relinquishment of Medical Staff member’s privileges upon expiration of his current term, without entitlement to the procedural rights provided in SECTION 8 of this Article.

Subsection B. Reappointment to any category of the Medical Staff shall be for a period of not longer than 24 October 2012
months. Appointments made after the start of the Medical Staff year shall be for the year of appointment only. The recommendations for reappointment and delineation of privileges of each member of the Medical Staff shall be made by the Medical Staff at their annual meeting after appraisal of each member by the Credentials Committee regarding the physical, mental, and clinical competence including continuing education and quality assessment review of the Medical Staff members in accordance with ARTICLE V, SECTION 2, SUBSECTION B of the Bylaws, so that action may be taken by the Board at its next meeting.

Subsection C. Should the Board wish to take the initiative in refusing to reappoint any member, it shall advise the Medical Staff within thirty (30) days of its action. A meeting shall then be held within ten (10) days of notification by the Board with an equal number of members of the MEC of the Board and the Medical Staff. If the reappointment is not recommended following this meeting the applicant may then appeal under SECTION 8 - Hearing and Appeal Procedure.

Subsection D. The privileges granted in this renewal process will be those requested by the Medical Staff member, recommended by the MEC, and approved by the Board. This renewal will be based on a reappraisal that will include consideration of professional performance, judgment, skills, and knowledge; the individual's current licensure; physical and/or mental health status; meeting the continuing education requirement; timely, complete, accurate, clear, and legible entries in medical records; the results of quality assessment activities; working relations with medical colleagues and others in the Healthcare; attendance at committee meetings; and other reasonable indication of continuing qualifications.

SECTION 9.  Investigations, Hearing and Appeal Procedure

1.  INVESTIGATIONS

1.1  Criteria for initiation

These bylaws encourage the use of progressive steps by medical staff and hospital management, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. All collegial intervention efforts by medical staff and hospital management are part of the hospital’s performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff and hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. This includes circumstances where information indicates a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be:

a. Detrimental to patient safety or to the delivery of quality patient care within the hospital;
b. Unethical;
c. Contrary to the medical staff bylaws, associated manuals, rules and regulations, or medical staff or hospital policies;
d. Below applicable professional standards of behavior or clinical management.

Following efforts at collegial intervention, if it appears that the practitioner’s performance places patients in danger or the quality of care is compromised, or in cases where it appears that patients may be placed in harm’s way while collegial interventions are undertaken, the MEC will consider whether a recommendation to restrict or revoke membership and/or privileges should be made to the Board. Before issuing such a
recommendation the MEC will authorize an investigation to determine whether sufficient evidence exists to support such a recommendation.

1.2. **Initiation**
A request for an investigation must be submitted by a [medical staff officer, committee chair, department/clinical service chief, CEO, CMO or hospital board chair] to the MEC through the president of the medical staff and supported by reference to the specific activities or conduct of concern. If the MEC initiates the request, it shall make an appropriate record of its reasons.

1.3 **Investigation**

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an Investigation.

The MEC may conduct the Investigation itself or may assign the task to an appropriate standing or ad hoc committee of the medical staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant necessary and such use is approved by the MEC and the CEO. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The practitioner of concern shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. This meeting (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a “hearing” as that term is used in the hearing and appeals sections of these bylaws, nor shall the procedural rules with respect to hearings or appeals apply. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

1.3.1 An external peer review consultant should be considered when:
   a. Litigation seems likely;
   b. The hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;
   c. There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors, partners, or associates of the physician under review.

2. **Hearing and Appeal Procedure**

2.1 Any individual whose appointment or reappointment to the Medical Staff or whose advancement in Medical Staff membership has received an adverse recommendation by the Board, or any individual whose clinical privileges have been curtailed, suspended, revoked or received an adverse recommendation by the Board, or any individual who has received an adverse recommendation from the Medical Staff relative to October 2012
matters of Medical Staff appointment or reappointment or Healthcare privileges shall unless otherwise provided have a right to a hearing by an ad hoc Judicial Review Committee. The ad hoc Judicial Review Committee of the Medical Staff will be composed of individuals, as set forth in ARTICLE V, SECTION 2, SUBSECTION I, PARAGRAPH 2.

2.2 Where there is imminent danger to the health of any individual, the Administrator or Medical Staff has the right to suspend or restrict clinical privileges, subject to subsequent notice and hearing or other adequate procedures.

2.3 The Administrator shall notify by certified letter within seven (7) days, return receipt requested, any individual affected as noted in Paragraph 1. This notice shall include a summary of the reasons for this action and the individual’s right to a hearing and an appellate review. An individual requesting such hearing has thirty (30) days following the date of receipt of any adverse notice regarding recommendations for Medical Staff membership and/or clinical privileges to this hospital to do so in writing, delivered in person or by mail to the MEC. Failure by the applicant to request hearing within 30 days of notice of adverse action shall be deemed to constitute voluntary acceptance of said action effective forthwith and the applicant hereby waives the right to a hearing.

2.4 The MEC shall, within ten (10) days after receipt of such request for hearing, arrange for such hearing in accordance with Subsection 6 of this Article and shall direct the President of the Medical Staff to appoint an ad hoc Judicial Review Committee in accordance with the provisions under ARTICLE V, SECTION 2, SUBSECTION I, paragraph 2. If the President of the Medical Staff is the individual requesting the hearing then the Vice President will have the duty to appoint the ad hoc Judicial Review Committee. The MEC shall state in writing in concise language the acts or omissions with which the individual is charged, a list of charts and any other records or documents being questioned, or the reasons for the denial of the request constituting the grounds for the hearing. The date of the hearing shall not be less than thirty (30) days or more than thirty-five (35) days from the date of receipt of the request for hearing, provided, however, that when a request for hearing is received from an individual who is under suspension which is then in effect, the hearing can be held in less than thirty (30) days at the request of the affected practitioner as soon as the arrangements may reasonably be made after receipt of the request for hearing.

2.5 When the requested hearing relates to a decision of the Board that is adverse to the practitioner and contrary to the recommendation of the Medical Staff, the Chairperson of the Board shall appoint an ad hoc Judicial Review Committee to conduct such a hearing, which shall be not less than thirty (30) days or more than thirty-five days after receipt of such request for hearing. This ad hoc Judicial Review Committee shall be composed of the Chairperson of the Board and two other members of the Board as appointed by the Chairperson, and the President of the Medical Staff, or the Vice President if the President of the Medical Staff is the individual requesting the hearing. The Chairperson of the Board shall designate the chairperson of this ad hoc Judicial Review Committee.

2.6 Hearing Procedure

(a) The Chairperson of the Board or the President of the Medical Staff or the Vice President of the Medical Staff, whichever is applicable, shall fix the place and time of the hearing and shall send, within ten (10) days after receipt of such request for hearing, by certified mail, return receipt requested, a notice of same to the individual requesting the hearing. Included in such notice shall be the statement of the MEC or Board with respect to the grounds for the adverse recommendation or decision, a list of the rights of the individual requesting the hearing, the available appellate procedure and a list of witnesses expected to testify.

(b) No hearing shall be conducted without the personal presence of the individual for
whom the hearing has been scheduled unless he waives in writing such appearance or fails without good cause to appear for the hearing after appropriate notice.

(c) Failure without good cause of the applicant or member of the Medical Staff requesting the hearing to appear and proceed at such hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved which shall become effective immediately and his waiver of all other rights inuring to him under the provision of these Bylaws. Postponements of hearings beyond the time set forth in these Bylaws shall not be permitted except with the consent of the applicant or member of the Medical Staff involved or except upon his request. In the latter case, granting a postponement shall only be for good cause shown and at the sole discretion of the MEC.

(d) The individual requesting the hearing shall be entitled to be accompanied by and/or represented at the hearing by a Medical Staff member in good standing or may be represented by an attorney as provided in paragraph 9 of this section. The aggrieved practitioner shall have the following rights: to examine all charts and other records and documents, to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness, to rebut any evidence, and testify on his own behalf. If the practitioner does not testify on his behalf, he may be called and examined. At the conclusion of the hearing, the practitioner shall have the option to submit a statement of his position for the record within three (3) days.

(e) The appointed chairperson of the ad hoc Judicial Review Committee or his designee shall preside over the hearing. He shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence and that decorum is maintained. He shall be entitled to determine the order of procedure during the meeting and shall make all rulings on matters of law, procedure, and the admissibility of evidence. A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. He shall also select the method to be used for making the record.

(f) The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The chairperson of the ad hoc Judicial Review Committee may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by the chairperson and entitled to notarize documents. The ad hoc Judicial Review Committee may require one or both parties to prepare and submit to the committee written statements of their position on the issues, prior to, during or after, the hearing.

(g) The MEC or the Board whose adverse action occasioned the hearing shall have the initial obligation to present evidence in support of its action. The Medical Staff member requesting the hearing shall have the burden of proving that the adverse action lacks substantial factual basis or that such conclusions drawn there from are either arbitrary, unreasonable, or capricious.

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Within ten (10) days after final adjournment of the hearing, the ad hoc Judicial Review Committee shall make a report and recommendation in writing to the MEC or the Board as the case may be. The report may recommend confirmation, modification, change, or rejection of the original recommendations or action. A copy of the written recommendation and statement of the basis of the decision will be sent by certified mail, return receipt requested, to the affected practitioner.

Within ten (10) days after receipt of the report and recommendations of the ad hoc Judicial Review Committee, the MEC shall render a written recommendation after consultation with the full Active Medical Staff, if applicable, and shall forward a copy of its recommendation and the basis of the recommendation to the Board and by certified mail, return receipt requested, to the affected practitioner. If the recommendation to this point has been favorable to the individual and privileges have been restricted because of suspension, he may be temporarily reinstated pending a final decision by the Board.

Within ten (10) days after receipt of the report and recommendations of the MEC or of the ad hoc Judicial Review Committee appointed by the Board, the Board shall render a written recommendation in the matter and shall forward a copy of its recommendation and a statement of basis upon which the recommendation was made to the individual for whom the hearing was held in person or by certified mail, return receipt requested, and to the secretary of the Medical Staff for report to the Medical Staff.

Failure of the individual to request an appellate review within ten (10) days following the date of receipt of an adverse recommendation by the Board shall constitute a waiver of such person's right to the same.

The hearings provided for in these Bylaws are for the purpose of resolution of matters bearing on professional competency and conduct. Nothing herein shall be deemed to deprive the practitioner, the MEC, or the Board of the right to legal counsel in connection with preparation for the hearing or for a possible appeal.

2.7 Appellate Review

Within ten (10) days after receipt of the adverse recommendation by the Board, the individual requesting the hearing may request in writing, delivered to the Board, an appellate review by the Board. If such appeal is not requested within ten (10) days, the Board's decision is final and it shall thereupon become effective immediately, and he shall have waived all rights due him under the provisions of these Bylaws. The request must state grounds for the appeal.

The appellate review by the Board shall be before the Board sitting as a whole and shall be conducted under the same procedures as are applicable to the ad hoc Judicial Review Committee. The appellate review shall be not less than ten (10) days or more than twenty (20) days after the receipt of an individual's request for an appellate review.

The proceedings by the Board shall be in the nature of an appellate review based upon the record of the hearing before the ad hoc Judicial Review Committee, that committee's report, and all subsequent results and actions thereon. The practitioner
shall present a written statement that describes the basis for his disagreement with the MEC or the ad hoc Judicial Review Committee’s recommendation.

(d) Within ten (10) days after the appellate proceedings before the Board, the Board shall render a final decision in the matter and shall send notice thereof to the MEC and through the President to the affected practitioner by certified, return receipt requested, informing him of the final decision by the Board and the reasons for that decision.

(e) The final decision of the Board, following the appellate procedure set forth in this section, shall be effective immediately and shall not be subject to further appeal.

(f) Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the MEC, or the Board or its duly authorized committees.

2.8 Any report, information, or accusation filed, or any action recommended under this section, shall be deemed a privileged communication.

2.9 If the practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance, his request for the hearing or appellate review must so state. In no event shall the affected practitioner, Medical Staff, or the Board be represented by an attorney at any phase of a hearing or an appellate review appearance unless both sides are permitted an opportunity to be so represented by legal counsel. The foregoing shall not be deemed to deprive the practitioner, the MEC, or the Board to the right to legal counsel in connection with preparation for a hearing or an appellate review.

2.10 Each member of the Medical Staff waives any right of personal redress against any individual member of the Medical Staff or the Board for disciplinary action taken under this article.

FLOW CHART OF THE HEARING AND APPEAL PROCEDURE

1. Adverse action which initiates hearing and appeal procedure.

2. Administrator notifies the individual of the adverse action by certified mail, return receipt requested, within seven (7) days.

3a. Individual requests hearing within thirty-five (35) days from receipt of notification of adverse action. See #4.

OR

3b. Failure of individual to request hearing within thirty-five (35) days of receipt of notification of adverse action constitutes a waiver of the individuals’ right to the hearing and appeal procedure. End of Procedure.

4. Hearing shall be arranged within ten (10) days following receipt of the individual’s request for a hearing.

5a. Date of hearing shall not be less than thirty (30) days or more than thirty-five (35) days from the date of receipt of the individual’s request for a hearing. See #6.
OR

5b. If the individual is under suspension which is then in effect, the date of the hearing at the request of the individual can be less than thirty (30) days from the date of receipt of the individual's request for a hearing. See #6.

6. Ad hoc Judicial Review Committee makes report and recommendation within ten (10) days after final adjournment.

7. MEC makes recommendation within ten (10) days from the date of receipt of the report and recommendation from the ad hoc Judicial Review Committee.

8. Board makes decision within ten (10) days from the date of receipt of recommendation from the MEC and notifies the individual by certified mail, return receipt requested.

9a. Individual requests appellate review within ten (10) days after date of receipt of the Board's decision. See #10.

OR

9b. Failure to request an appellate review within ten (10) days of the date of receipt of the Board's decision constitutes a waiver of the individual's right to an appeal. The Board's decision is final and becomes effective immediately. End of Procedure.

10. Date of appellate review shall be not less than ten (10) days or more than twenty (20) days from the date of receipt of the individual's request for an appellate review.

11. Board renders final decision within ten (10) days after the appellate review proceedings and notifies the individual by certified mail, return receipt requested.

12. The final decision by the Board shall be effective immediately and shall not be subject to further appeal.

SECTION 10. Resignation from Medical Staff

The physician must apply in writing to the MEC for resignation. Resignation is not accepted unless medical staff responsibilities are completed. If this does not occur, the physician is considered to have "resigned while not in good standing" and the inactive file will indicate such.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

SECTION 1. Medical Staff

The Medical Staff shall be divided into active, associate, courtesy, honorary, temporary, consulting, dental, and podiatry categories.

October 2012
SECTION 2. Active Medical Staff

Subsection A. The Active Medical Staff shall consist of actively participating physicians who reside in the community and who have been granted appointment to the Medical Staff with delineation of privileges in accordance with ARTICLE III.

Subsection B. Members of the Active Medical Staff shall be eligible to vote, to hold office, and to serve as consultants in accordance with the Medical Staff Bylaws, Rules and Regulations.

Subsection C. Members of the Active Medical Staff shall serve on committees and vote on matters before such committees.

Subsection D. Members of the Active Medical Staff shall be required to attend Medical Staff meetings as provided in ARTICLE VI of these Bylaws.

SECTION 3. Associate Medical Staff

Subsection A. The Associate Medical Staff shall consist of actively participating physicians, who are newly appointed to the Medical Staff in accordance with ARTICLE III, and are being considered for advancement to the Active Medical Staff after serving six (6) months as an Associate Medical Staff member. The Associate Medical Staff member shall have his privileges delineated in the same manner as the Active Medical Staff member, i.e. by submitting a request for privileges and having them approved by the Medical Staff and the Healthcare Board.

Subsection B. A member of the Associate Medical Staff may serve on Medical Staff committees and vote on matters before such committees.

Subsection C. Members of the Associate Medical Staff shall be required to attend Medical Staff meetings as provided in ARTICLE VI of these Bylaws. However, they shall have a voice but not a vote and are ineligible to hold office.

Section 4. Locum/Contract Staff

Qualifications:

Locum/Contract Medical Staff Members shall consist of those Practitioners who:

a) Satisfy the general qualifications for appointment, including completion of an Accredited Residency and Board Certification or Board eligible as set forth in these Bylaws and in the Appointment Policy as applicable to the Practitioner;

b) Provide care through a locum or contract agreement; and

c) Not required to meet the geographic requirements.

Prerogatives and Responsibilities:

Locum/Contract Staff Members shall not have any of the prerogatives or responsibilities granted to or imposed upon other Members of the Medical Staff and shall have Clinical Privileges limited to the locum/contract agreement.

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Locum/Contract Staff Members may, but are not required to, attend Medical Staff and committee meetings. Locum/Contract Staff Members are not eligible to vote for or serve as Medical Staff officers, Chair of Departments or Medical Staff committees or as members of standing or special Medical Staff committees unless specifically appointed to such committees. Locum/Contract Staff Members may attend Hospital and Medical Staff educational programs. Locum/Contract Medical Staff shall pay such fees and assessments as may be established from time to time by the Medical Executive Committee and approved by the Board of Directors.

Locum/Contract Staff Members shall participate in provisional monitoring of three (3) cases if the period of membership is less than six (6) months and six (6) cases if greater than six (6) months.

Locum/Contract Staff Members with no activity over twelve (12) month period will be processed as a voluntary resignation.

Locum/Contract Staff Members are responsible for participation in emergency call as specified by their department.

SECTION 5. Courtesy Medical Staff

Subsection A. The Courtesy Medical Staff shall consist of practicing physicians who meet the qualifications for membership as prescribed in ARTICLE III, except that he may or may not reside in the community. For reasons other than the above, he may not desire appointment to the Active Medical Staff, but may desire to care for private patients in Holy Rosary Healthcare. A Courtesy Medical Staff member may only admit, order, or treat, under the direct supervision of an Active Medical Staff member.

Subsection B. Members of the Courtesy Medical Staff shall be under the direct supervision of a physician, such supervising physician to have privileges in the same medical field as the Courtesy Medical Staff member.

Subsection C. Courtesy Medical Staff members may, but are not required to, attend Medical Staff meetings. They are ineligible to vote, hold office, hold committee appointments, or have an active voice in Medical Staff administration or procedures.

SECTION 6. Honorary Medical Staff

1. Former Active Medical Staff members who have retired or are in semi-retirement.
2. Physicians of outstanding reputation, not necessarily a resident in the community.

The Honorary Medical Staff may be appointed by the Board on recommendation of the Active Medical Staff and shall have no assigned duties or responsibilities. They shall not be eligible to hold office or vote. They are not eligible to admit patients to Holy Rosary Healthcare and have no clinical privileges.

SECTION 7. Temporary Medical Staff

Subsection A. The Temporary Medical Staff shall consist of physicians granted Temporary Medical Staff privileges in accordance with ARTICLE III, SECTION 5, SUBSECTIONS J and K.

Subsection B. Temporary Medical Staff members may attend meetings and may be required to attend committee meetings as designated by the President of the Medical Staff.

Subsection C. Temporary Medical Staff members shall not be eligible to vote and shall be ineligible to hold office.
SECTION 8. Consulting and Telemedicine Medical Staff

Subsection A. The Consulting Medical Staff shall consist of physicians who by virtue of their expertise of specialty training may be asked to see and evaluate patients at the request of an Active Medical Staff member. The Consulting Medical Staff members shall have their privileges delineated by submitting a request for privileges and have them approved by the Medical Staff and the Board as established in ARTICLE III, SECTION 6.

Subsection B. The Consulting Medical Staff may, but are not required to, attend Medical Staff meetings. They are ineligible to vote, hold office, hold committee appointments, or have an active voice in Medical Staff administration or procedures.

Subsection C. Telehealth Consultant - A practitioner may be credentialed to provide medical services from outside the hospital to patients within the hospital system via Telemedicine.

The applicant will request an application to the Medical Staff for telemedicine privileges. There are four circumstances by which practitioners may come to request telemedicine privileges:

<table>
<thead>
<tr>
<th>CIRCUMSTANCE</th>
<th>PROCEDURE</th>
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</thead>
<tbody>
<tr>
<td>Hospital contracts with TJC approved organization for telemedicine services</td>
<td>No credentialing required; however, copy of privilege list from TJC facility required. Contract provides for credentialing criteria. HRH will continue to primary source verify the National Practitioner Data Bank and Professional References.</td>
</tr>
<tr>
<td>Hospital contracts with non-TJC approved organization or provider for telemedicine services</td>
<td>Standard credentialing process is used for practitioner to obtain privileges.</td>
</tr>
<tr>
<td>TJC approved provider or organization without a hospital contact requests telemedicine privileges</td>
<td>HRH may use the distant site’s credentialing information via the MT Region Telemedicine Credential Form. HRH will continue to primary source verify the National Practitioner Data Bank and Professional References.</td>
</tr>
<tr>
<td>Non-TJC approved provider or organization without a hospital contact requests telemedicine privileges</td>
<td>Standard credentialing process is used for practitioner to obtain privileges.</td>
</tr>
</tbody>
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After all information has been received, the application will be forwarded to the Chairperson of the Credentials Committee for review. After review by the Chairperson, the application will proceed through the normal Credentials process.

SECTION 9. Dental and Podiatry Staff

Subsection A. Privileges granted to dentists and podiatrists shall be based on their training, experience, and demonstrated competence and judgment.

Subsection B. The scope and extent of surgical procedures that each dentist and podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of Surgery or his designee.

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Subsection C. The dentist or podiatrist shall be responsible for writing a timely dental or podiatric history and physical for each patient treated.

Subsection D. All dental and podiatric patients shall have a history and physical done by a physician who shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during the hospitalization and who shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

Subsection E. In event of any problems that arise, the physician shall call any consultation he feels necessary.

SECTION 10. Disaster Privileges

Disaster privileges may be granted only when the following two conditions are present: disaster plan has been activated and the organization is unable to handle the immediate patient needs.

(a) The Chief Executive Officer or Medical Staff President or his or her designee(s) has (have) the option to grant disaster privileges.

(b) The responsible individual(s) is (are) not required to grant privileges to any individual and is (are) expected to make such decisions on a case-by-case basis at his or her discretion.

(c) The Medical Staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges.

(d) In order for volunteers to be considered eligible to act as practitioners, the organization obtains for each volunteer practitioner, at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport), and at least one of the following:

(1) A current license to practice in a United States or Canadian jurisdiction.

(2) Primary source verification of the license.

(3) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC, or Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VH)) or other recognized state or federal organizations or groups.

(4) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).

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

(e) If not immediately available, primary source verification of licensure begins as soon as the emergent situation is under control, and is completed 72 hours from the time the volunteer practitioner presents to the organization.

(f) The medical staff oversees the professional practice of volunteer practitioners.

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(g) The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted. NOTE: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication 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: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

(h) These individuals will be identified to staff.

SECTION 11. Leave of Absence

A Medical Staff member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC and the President of the Medical Staff, which states the period of time for the leave, which may not exceed the remainder of the current staff appointment. A leave of absence request may be granted by the MEC, subject to such conditions or limitations as the MEC shall determine to be appropriate. During the period of a leave, the Medical Staff member's privileges and prerogatives shall not be exercised. At least thirty (30) days prior to the termination of the leave, or at any earlier time, the Medical Staff member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the President of the Medical Staff for transmittal to the MEC.

ARTICLE V

ORGANIZATION OF THE MEDICAL EXECUTIVE COMMITTEE

SECTION 1. Officers

The Officers of the Medical Executive Committee shall be the President of the Medical Staff, Vice President, Immediate Past President, and Secretary. The chief executive officer (CEO) of the hospital or his or her designee attends each medical staff executive committee meeting on an ex-officio basis, without a vote. New officers shall be elected at the annual meeting of the Medical Staff, and shall hold office for (2) two years or until a successor is elected.

Subsection A. Qualifications of Officers of the Medical Executive Committee

Officers must be members of the Active Medical Staff at the time of nomination and election to the office must be members of the Active Medical Staff in good standing and must remain in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved, to be filled in accordance with SECTION 1, SUBSECTION B of this Article. Additional specific qualifications would include:

- Indicate a willingness and ability to serve;
- have no pending adverse recommendations concerning medical staff appointment or clinical privileges;
- encourage continuing education relating to the medical staff leadership and/or credentialing/quality review functions prior to or during the term of office.
- have excellent administrative and communication skills, and;

Subsection B. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the President of the Medical Staff, shall be filled by the MEC of the Medical Staff. If there is a vacancy in the office of the President of the Medical Staff, the Vice President shall serve out the remaining term.

Subsection C. Removal from Office

An officer may be removed from office on three fourths (3/4) majority of Medical Staff Members eligible to vote, at a meeting called on at least 30 days notice for that purpose. The MEC committee will appoint a replacement to complete the current term. Grounds for removal shall include, but not be limited to, physical and/or mental impairment that significantly impairs the officer's ability to perform the essential functions and duties of the position or inability and/or unwillingness to perform the duties and responsibilities of the office.

Subsection D. Duties of the Officers

1. President of the Medical Staff. The President of the Medical Staff shall serve as the chief administrative officer of the Medical Staff to:
   a. Act in coordination and cooperation with the Administrator in all matters of mutual concern within the Healthcare.
   b. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
   c. Chair the MEC.
   d. Serve as ex officio member of all Medical Staff Committees.
   e. Represent the Medical Staff as an ex officio member at all regular meetings of the Board and any other meetings of the Board when requested.
   f. Recommend to the MEC committee members to appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees except for the MEC.
   g. Represent the views, policies, needs and grievances of the Medical Staff to the Board and to the Administrator.
   h. Receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.
   i. Appoint Medical Directors for Healthcare services as required by accrediting/licensing organizations.

2. Vice President
   a. In the absence of the President of the Medical Staff, he shall assume all the duties and responsibilities of the President.
have the authority of the President of the Medical Staff. He shall be a member of the MEC. He shall automatically succeed to the President of the Medical Staff when the latter fails to serve for any reason.

3. Immediate Past President of the Medical Staff
   a. Serves in an advisory capacity to the President of the Medical Staff and also serves on the MEC.

4. Secretary
   a. The secretary shall keep accurate and complete minutes of all meetings, call meetings on order of the President of the Medical Staff, attend to all correspondence, perform such other duties as ordinarily pertain to his office and also serves on the MEC. If there are funds to be accounted for, he shall also act as treasurer.

SECTION 2. Committees

Committees of the Medical Staff shall be Standing and Special. All Standing committee appointments are for a period of one year. All committees other than the MEC shall be appointed by the President of the Medical Staff and report directly to the MEC.

Subsection A. The MEC shall consist of the President of the Medical Staff, Vice President, Immediate Past President of the Medical Staff, and Secretary of the Medical Staff and no more than three ex officio members appointed by the Administrator.

The duties of this committee shall be:

1. To represent and to act on behalf of the Medical Staff, subject to limitations as may be imposed by these Bylaws.
2. To serve as an investigative and processing committee for allegations of impairment of Medical Staff members or allied health professional staff.
3. To coordinate the activities and general policies of the Standing and Special committees.
4. To receive and act upon committee reports and report on actions taken to the Medical Staff.
5. To implement policies of the Medical Staff not otherwise the responsibility of the Special or Standing committees.
6. To provide liaison between the Medical Staff, Administrator and the Board.
7. To recommend action to the Administrator on matters of a medico-administrative nature.
8. To make recommendations on Healthcare management matters such as long-range planning to the Board through the Administrator.
9. To be responsible for recommending to the Board for its approval, issues regarding Medical Staff structure, Medical Staff membership and individual’s application for privileges, monitoring quality of care delivered by individual practitioners who are privileged by medical staff, as well as leading and participating the performance improvement & patient safety initiatives within the
10. To ensure that the Medical Staff is kept abreast of the accreditation status of the Healthcare.

11. To provide for the preparation of all meeting programs, either directly or through delegation to a program chairperson.

12. To report to each general Medical Staff meeting, and maintain a permanent record of its proceedings and actions.

13. To be responsible for the enforcement of these Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

14. To assure quality of care for all patients as well as compliance with applicable Joint Commission quality assurance standards as outlined in the hospital annual Quality Improvement Plan.

15. Meetings – The MEC shall meet at least once a month unless waived by the President of the Medical Staff.

16. The MEC will appointment at least 30 days prior to annual meeting.

All other Medical Staff Committees are listed in the Administration Policy under the title of Medical Staff Committee.

Committees of the Medical Staff shall be Standing and Special. All Standing committee appointments are for a period of one year. All committees other than the Executive Committee shall be appointed by the President of the Medical Staff and report directly to the Executive Committee.

Subsection B. Credentials Committee

1. Composition: The Credentials Committee shall be a Standing Committee consisting of not less than three members, the number and selection being determined in such a manner to insure representation of the different services on the Medical Staff. The President of the Medical Staff shall be a member ex officio.

2. Duties of this committee shall be:

   a. To investigate the character, qualifications, letters of recommendation, and credentials of all applicants for membership and to make recommendations, conforming with ARTICLE III, SECTION 5, SUBSECTION B of these Bylaws.

   b. To carry out the established policies and procedures for the evaluation of Medical Staff applicants with a history of chemical impairment.

   c. To review all information available regarding the physical, mental, and clinical competence of Medical Staff members and as a result of such review to make recommendations for the granting of privileges and the appointment and/or
reappointment of members to the Medical Staff.

d. To properly screen physicians and allied health professionals in compliance with these Bylaws and the rules and regulations, policies and procedures now existing or hereafter adopted by the Medical Staff.

e. Minutes of Committee meetings shall reflect that a majority of committee members have concurred for a recommendation to be taken to the Executive Committee.

f. To develop criteria for privileges as appropriate.

Subsection C. Surgery and Anesthesia Committee

1. Composition: The Surgery and Anesthesia Committee shall be a Standing Committee consisting of at least three members of the surgical Medical Staff and no more than three ex officio members appointed by the Administrator.

2. Duties of this committee shall be:

a. To review practices and procedures in the operating suite and to suggest any appropriate changes to the Executive Committee.

b. To review the practices and procedures rendered by anesthetists in the Surgical-Obstetrical areas, development of safety regulations, and suggest appropriate changes to the Executive Committee.

c. To function as a Physical Medicine Committee reviewing practices and procedures and suggest appropriate changes to the Executive Committee.

d. Written minutes of all its activities shall be transmitted to the Executive Committee.

e. To review practices and procedures in the Same Day Surgery department and to suggest any appropriate changes to the Executive Committee.

f. To assure quality of care for all patients as well as compliance with applicable Joint Commission quality assurance standards as outlined in the hospital annual Quality Improvement Plan.

3. Meetings: The Surgery and Anesthesia Committee shall meet on an as needed basis, at a date and place, which shall be determined by the chairperson upon notice to all members.

Subsection D. Medical, Pharmacy and Therapeutics Committee

1. Composition: The Medical, Pharmacy and Therapeutics Committee shall be a Standing Committee consisting of at least six physicians and no more than three ex officio members appointed by the Administrator. Any interested physician on the Active Staff may attend this meeting.

2. Duties of this committee shall be:

a. To develop and review all drug utilization policies, practices, and drug reactions within October 2012
the Health Center in order to assure optimum clinical results and a minimum of potential hazard.

b. To assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, safety procedures and all other matters relating to drugs in the Health Center.

c. To function as a Respiratory Therapy Committee.

d. To be responsible for the formulation, evaluation, maintenance and improvement of policies and procedures for the care and treatment of patients in the acute and extended care units of the hospital. Particular attention shall be directed to the admission, transfer and discharge criteria of these units. In the fulfillment of these charges, liaison with other departments will be maintained.

e. To keep written minutes of all its activities and transmit those minutes to the Executive Committee.

f. To assure quality of care for all patients as well as compliance with applicable Joint Commission quality assurance standards as outlined in the hospital annual Quality Improvement Plan.

g. To develop a drug formulary and review all requests for changes to the drug formulary for the health center.

3. Meetings: The committee shall meet at least quarterly at a date and place which shall be determined by the chairperson upon notice to all members.

Subsection E. Emergency Committee

1. Composition: The Emergency Committee shall be a Standing Committee consisting of at least four physicians representing at least pediatrics, internal medicine, surgery and obstetrics, one Emergency Room physician assistant and the Emergency Room Nurse Manager appointed annually. All emergency room PAs and their sponsors are required to attend the meeting as non-voting members. Any interested personnel will be invited to attend.

2. Duties of this committee shall be:

a. To be responsible for the formulation, evaluation, maintenance and improvement of policies and procedures for the care and treatment of patients in the Emergency department of the Health Center. Particular attention shall be directed to the admission, transfer and discharge criteria of this unit. In the fulfillment of these charges, liaison with other departments will be maintained.

b. To facilitate continuing education for physicians, physician assistants and nurses.

c. To transmit written minutes of all its activities to the Executive Committee.

d. To be responsible for the formulation, evaluation, maintenance and improvement of policies and procedures for the care and treatment of patients in the emergency services of the Health Center.
e. To serve as the peer review committee for practitioners providing emergency room coverage.

f. To assure quality of care for all patients as well as compliance with applicable Joint Commission quality assurance standards as outlined in the hospital annual Quality Improvement Plan.

g. To review Emergency Room problems that arise between meetings and forward them to the Chairperson of the committee serving as the ER Director for resolution. The problem will then be forwarded to the committee at the next meeting.

3. Meetings: The Emergency Committee shall meet at least quarterly unless waived by the Chairperson at a date and place which shall be determined by the chairperson upon notice to all members. The agenda to the Emergency Committee will be distributed to all members of the Medical Staff for review.

Subsection F. Perinatal Committee

1. Composition: The Perinatal Committee shall be a Standing Committee consisting of at least three physicians representing the area of obstetrics, pediatrics and family practice and no more than three ex officio members appointed by the Administrator.

2. Duties of this committee shall be:

   a. To be responsible for the formulation, evaluation, maintenance and improvement of policies and procedures for the care and treatment of obstetrical, perinatal and neonatal patients. In the fulfillment of charges, liaison with other departments will be maintained.

   b. Written minutes of all its activities shall be transmitted to the Executive Committee.

   c. To assure quality of care for all patients as well as compliance with applicable Joint Commission quality assurance standards as outlined in the hospital annual Quality Improvement Plan.

3. Meetings: The Perinatal Committee shall meet on a quarterly basis at a date and place which shall be determined by the chairperson upon notice to all members.

Subsection G. Bylaws Committee

1. Composition: The Bylaws Committee shall be a Standing Committee and consisting of four physicians appointed annually. The President of the Medical Staff will serve as ex officio.

2. Duties of this committee shall be:

   a. To review the Bylaws, Rules and Regulations every three years and as needed for consideration of revisions and amendments and act upon any proposals for the same that may originate from Health Center services, the Executive Committee or an Active Medical Staff member.

   b. The every three year review of the Bylaws, Rules and Regulations and other actions of this committee must be documented by committee meeting minutes and other
material, if appropriate, such as drafts of changes and revisions of the Bylaws, Rules and Regulations.

3. Meetings: Meetings shall be held at a date and place which shall be determined by the chairperson of the committee upon notice to all members. The Bylaws Committee shall forward meeting minutes to the Medical Staff as available.

Subsection H. Nominating Committee

The Nominating Committee shall be a Standing Committee, appointed by the Executive Committee one month prior to the annual meeting. Its purpose shall be to take nominations to the entire Medical Staff at least two weeks prior to the annual meeting in April. The President of the Medical Staff shall be a member ex officio.

Subsection I. Special Committees

1. Special Committees: Special Committees shall be appointed from time to time as the need arises to carry out the duties of the Medical Staff. These committees shall confine their activities to the purpose for which they were created and shall make reports of their actions and proceedings to the Executive Committee.

2. Hearing and Appeal ad hoc Judicial Review Committee of the Medical Staff:

   a. This Special Committee shall consist of not less than three members of the Active Medical Staff, appointed by the President of the Medical Staff (or the Vice President if the President of the Medical Staff is the individual seeking the hearing), in consultation with the Executive Committee. One member must be the Chairperson of the Credentials Committee. The President of the Medical Staff or Vice President, whichever is applicable, shall designate one member as the chairperson.

   b. A Medical Staff or Board member who has participated in the initiation of an adverse recommendation which has precipitated a hearing shall not serve on the ad hoc Judicial Review Committee. Further, a Medical Staff or Board member shall not be disqualified from serving on the ad hoc Judicial Review Committee because he has heard of the case or has a basic knowledge of the facts involved in the case. No one shall participate if he is in direct economic competition with the affected practitioner. In any event, all members of the ad hoc Judicial Review Committee shall be required to consider and decide the case with good faith objectivity.

   c. There shall be at least a simple majority of the members of the ad hoc Judicial Review Committee present when the hearing takes place. No member may vote by proxy. Any member absent from any part of the proceedings shall not be permitted to vote.

Subsection J: Utilization Review Committee

1. Composition: The Utilization Review Committee shall be a Standing Committee consisting of at least two members of the Medical Staff who are Doctors of Medicine or Osteopathy who are approved by the President of the Medical Staff. The President of the Medical Staff may appoint other medical staff representatives. Additional members include representatives from hospital leadership, finance, quality and health information management.

2. Duties of this committee shall be to:
a. Approve a continuing Utilization Management Plan which complies with the Federal, State and County regulations and any special contractual agreements which the hospital has signed.

b. Define the scope of Utilization Review activities to be performed within the hospital.

c. Review and update the Utilization Management Plan at least annually.

d. Develop annual goals and communicate these goals to hospital leadership and physicians.

e. Analyze the outcomes of all review activities to identify problems regarding utilization of servicers, quality of care and inappropriate practice patterns.

f. Make recommendations for changes in hospital policies, procedures and/or medical staff practices to address identified problems based on review activities.

g. Maintain a liaison with other medical staff and hospital committees in order to review the results of other quality assurance studies that may identify areas which impact the provision of quality, cost-effective care.

h. Monitor and ensure that discharge planning activities facilitate the continuity of care as the patient progresses from acute care status to a level requiring alternate delivery modes or support services.

i. Assists review activities, as requested by the Case Manager, specifically by:
   a) Reviewing actual or potential denied days of care or costs received from payors or anticipated from payors that result from lack of medical necessity and delays in service.
   b) Assisting with the initiation of appeals, peer-to-peer reviews and education of Medical Staff to avoid denials.

3. Meetings:
   a. The committee will convene at least every other month.
   b. The committee will maintain a record of its proceedings and actions and report the outcomes of its work to the Medical Executive Committee.

Subsection K: MEDICAL STAFF QUALITY IMPROVEMENT COMMITTEE

1. Composition:

The Medical Staff Quality Improvement Committee shall consist of at least four (4) members of the Medical Staff. Providers from other specialties may be invited to the meetings of the Committee as needed.

2. Responsibilities:

The Medical Staff Quality Improvement Committee will be responsible for evaluating and improving Practitioner and Allied Health Professional performance. The goals of the committee are:

*Improving patient outcomes;*

*Encouraging the pursuit of excellence;*

*Increasing efficiency of the Practitioner and Allied Health Professional performance evaluation;*
Supporting Medical Staff educational goals; and

Ensuring the efficient use of Practitioner, Allied Health Professional and quality staff measurement resources.

3. Goals:

In support of such goals the Quality Improvement Committee shall:

a) Establish a planned and systematic process for monitoring, evaluating, and improving the quality and appropriateness of the care and treatment of patients served by Members of the Medical Staff and Allied Health Professionals and the clinical performance of all individuals with Clinical Privileges. This monitoring and evaluation shall be conducted not less frequently than as required by Joint Commission or, if more frequently, as required by state or federal law (including applicable regulations).

b) The identification and collection of information about important aspects of patient care provided by the Medical Staff and Allied Health Professionals.

c) The identification of the indicators used to monitor the quality and appropriateness of the important aspects of care.

d) The periodic assessment of patient care information to evaluate the quality and appropriateness of care, to identify opportunities to improve care, and to identify important problems in patient care. Patient care reviews shall include all clinical work performed by the Medical Staff and Allied Health Professionals.

e) Recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital. These plans may include mechanisms to:

- establish systems to identify potential problems in patient care,
- set priorities for action on problem correction,
- refer priority problems for assessment and corrective action to appropriate departments or committees,
- monitor the results of quality improvement activities throughout the Hospital; and
- coordinate quality improvement activities;

- submit regular written confidential reports to the Medical Executive Committee on the quality of medical care provided and on peer review activities conducted and such other matters within the duties of the Committee as may be requested from time to time by the Medical Executive Committee;

- evaluate the appropriateness of blood transfusions;

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develop proposed policies and procedures for the screening, distribution, handling and administration of blood and blood components;

meet regularly for the purpose of receiving, reviewing and considering findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care provided to patients and the results of the Department's other review and educational activities, and the purpose of preparing and receiving reports on other Department and Staff functions;

evaluate the appropriateness of operative, other invasive and noninvasive procedures, including selection of the procedure, preparation of the patient, performance of the procedure and patient monitoring, post-procedure care and post-procedure patient education;

receive, evaluate and recommend practices related to infection control issues; and

receive and take action to improve prevention and control activities and to reduce nosocomial infections.

4. Meetings:

The Medical Staff Quality Improvement Committee shall meet as often as needed to satisfy its functions.

ARTICLE VI

MEMBER RIGHTS

1. Each member of the medical staff in the active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC. In the event such active member is unable to resolve a matter of concern after working with the [dept/service chiefs] or other appropriate medical staff leader(s), that active member may, upon written notice to, and approval of the president of the medical staff two (2) weeks in advance of a regular MEC meeting, meet with the MEC to discuss the issue.

2. Each member of the medical staff in the active category has the right to initiate a recall election of a medical staff officer or at-large-member of the MEC by following the procedure outlined in [Article IV, Section, 7] of these bylaws, regarding removal and resignation from office.

3. Each member of the medical staff in the active category may call a general medical staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by 25% of the members of the active category, the MEC shall schedule a general medical staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

4. In the event that a rule, regulation or policy is thought to be inappropriate, any active member may submit a petition signed by 10% of the members of the active category. When the MEC has received such petition, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or (2) schedule a meeting with the petitioners to discuss the
issues.

5. Each member of the medical staff in the active category may call for a clinical service meeting by presenting a petition signed by 10% of the members of the clinical service. Upon presentation of such a petition the clinical service chief will schedule a clinical service meeting.

6. The above Article VI Section 1-6 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II: Investigations, Corrective Action, Hearing and Appeal Plan provide recourse in these matters.

7. Any medical staff member has a right to a hearing/appeal pursuant to the medical staff’s hearing and appeal procedure (Investigations, Corrective Action, Hearing and Appeal Procedure).

ARTICLE VII

MEETINGS

SECTION 1. The Annual Meeting

The annual meeting of the Medical Staff shall be held in April. At this meeting the MEC shall make such reports as may be desirable, officers for the ensuing year shall be elected and recommendations for reappointment to the Medical Staff shall be made.

SECTION 2. Regular Meetings

Regular meetings of the Medical Staff shall be held monthly unless waived by the President of the Medical Staff and shall be for the purpose of:

1. Review of minutes of previous meetings, Standing and Special committee minutes.
3. Old and New Business.

SECTION 3. Special Meetings

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff and shall be called at the request of any five members of the Active Medical Staff.

SECTION 4. Committee Meetings

Committees will meet regularly as prescribed in Article V, Section 2.

SECTION 5. Attendance at Meetings

Subsection A. Medical Staff Meetings - Members of the Active and Associate Medical Staff shall be required to attend all meetings. The secretary shall maintain a record of attendance for each meeting. Members are required to attend at least ½ of all of the regular meetings of the year.

Subsection B. Committee Meetings - Members of the Active and Associate Medical Staff shall be required to attend ¾ of meetings.

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Subsection C. Committee meetings shall be scheduled so as to take into account all of the members' time schedules.

Subsection D. In addition to matters of organization, the programs of such meetings must be limited largely to findings from retrospective medical care evaluation studies and the review of current or recent cases in the Healthcare.

SECTION 6. Quorum

A majority of the members of the Active Medical Staff shall constitute a quorum for the Medical Staff meetings. A majority of the members (Active and Associate) of a committee shall constitute a quorum for Medical Staff committee meetings.

SECTION 7. Agenda

The Agenda of any regular meeting shall be:

1. Call to Order
2. Approval of Minutes
3. Information Review
4. Business
5. Other
6. Adjournment

ARTICLE VIII

ALLIED HEALTH PROFESSIONALS (AHPs)

SECTION 1. Definition

Allied Health Professional means an individual other than a licensed physician whose patient care activities require that his authority to perform specified patient care services be processed through the usual Medical Staff channels. Such affiliates may include, but are not limited to, clinical nurse specialists, clinical pharmacologists, optometrists, doctoral scientists, nurse clinicians, nurse practitioners, physician assistants, psychologists, psychiatric social workers, speech/language pathologists, audiologists, respiratory therapists, physical therapists, nurse anesthetists, surgical technicians, chemical dependency counselors and mental health providers.

SECTION 2. Qualifications

Only Allied Health Professionals who are qualified legally, professionally, and ethically and who agree to abide by these Medical Staff Bylaws, Rules and Regulations, where appropriate, shall be authorized to provide specified patient care services in the hospital following appointment.

SECTION 3. Procedure for Appointment and Specification of Services

Applications for appointment, reappointment, and specified services for Allied Health Professionals shall be submitted and processed in the same manner as provided in ARTICLE III for Medical Staff membership and clinical privileges. Allied Health Professionals shall be individually assigned to the clinical service appropriate to their professional training and except for Healthcare employees, shall be subject in general to the same terms and conditions of appointment as specified for Medical Staff appointment.

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SECTION 4.  Prerogatives

1.  Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff and consistent with the limitations of their privileges.

2.  Application for the privileges to write orders shall be made to the Credentials Committee for review and acted upon by the Active Medical Staff.

3.  Allied Health Professionals may serve on staff, department and Healthcare committees in ex officio capacity when requested by the assigned Active Staff physician.

4.  Exercise such other prerogatives as may, by resolution or written policy duly adopted by the Medical Staff and approved by the Board, be accorded to Allied Health Professionals as a group or to any specific category of professionals.

   a.  Certified Registered Nurse Anesthetists will be in accordance with CMS guidelines and Montana State Law.

SECTION 5.  Responsibilities

Each Allied Health Professional shall:

1.  Retain under the supervision or direction of a physician member of the Medical Staff appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Healthcare for whom he is providing services, or arrange a suitable alternative for such care and supervision.

2.  Participate as appropriate in the patient care audit and other quality maintenance activities required by the Medical Staff, in supervising provisional appointees of his same profession and in discharging such other Medical Staff functions as may from time to time be required.

3.  Satisfy the requirements set forth in ARTICLE VI for attendance at meetings of the Medical Staff and of the service and committees to which he is assigned.

SECTION 6.  Professional Review Actions Against Allied Health Professionals

For the purpose of this paragraph, the definitions of Professional Review Action and Professional Review Activity include review of AHPs.

1.  Non-Professional Review Actions: The Holy Rosary Healthcare may affect adversely the Clinical Privileges of an AHP with or without cause and without any right to appeal when the reason does not relate to the professional competence or conduct of the AHP.

2.  Professional Review Actions: Before the Holy Rosary Healthcare may take a Professional Review Action that affects adversely the Clinical Privileges of an AHP, the AHP is entitled to the hearing and appeal procedures of this subparagraph only.  The procedures of the Fair Hearing listed in Article III Section 9 of these Bylaws do not apply to AHPs.

3.  The President of Medical Staff may recommend a Professional Review Actions against an AHP by delivering a written recommendation to the MEC outlining the proposed action and the reasons for it.  Upon receipt of the request, the MEC must notify the AHP in writing of the

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recommendation, enclose a copy and afford the AHP a reasonable opportunity to request a hearing. Failure of the AHP to request a hearing with five (%) days authorizes the MEC to recommend action to the Board without further notice or proceedings.

4. If the AHP requests a hearing, the MEC must schedule one before it or an ad hoc subcommittee within a reasonable time and notify the AHP of the date and time. No prescribed procedure is required. The hearing committee may specify reasonable rules, rights and procedures in advance and at the hearing to ensure that both the AHP and recommending Member have a reasonable opportunity to be heard.

5. At the conclusion of the hearing, the hearing committee must prepare a recommendation to the MEC within a reasonable time. Member who originally recommended the action may not vote. The MEC must prepare a written decision, with reasons, and provide a copy to the AHP. The decision must notify the AHP of a reasonable time to appeal.

6. An AHP whose Clinical Privileges have been affected adversely by the MEC decision may appeal to the decision to the Board. Other decisions are not appealable. If the AHP does not appeal, the decision of the MEC is final pending approval by the Board.

7. On appeal, the Board may take such steps and make such inquiry as may properly inform it of the issues on the appeal. It may, but need not, request written submissions or oral argument and may take, or decline to take, any action to bring about just and speedy disposition of the appeal. It must inform the AHP of its decision, with its reasons, in writing. The decision of the Board is final.

8. The limitation of termination of Privileges of a supervising Member results in a comparable limitation or termination or the Privileges of the AHPs he or she supervises. Such limitation or termination is not a Professional Review Action and does not entitle the AHP to any hearing or appeal rights.

ARTICLE IX

DEFINITION OF RULES AND REGULATIONS

The Medical Staff shall adopt such rules, regulations, policies and procedures not inconsistent with these Bylaws as it may deem necessary for the proper conduct of its work, governance and discipline of the Medical Staff and assurance of quality of care to patients. Such rules, regulations, policies and procedures shall be adopted, repealed or amended at any regular meeting, without prior notice required, by a majority of vote of the MEC for 90 days at such time it must be ratified by a vote of the general medical staff. Such rules, regulations, policies and procedures shall become effective upon their approval by the Board. If any such rule, regulation, procedure or policy shall conflict with any of these bylaws, these bylaws shall prevail.

ARTICLE X

NON-COMPLIANCE TO BYLAWS AND/OR RULES AND REGULATIONS

SECTION 1. Allegations or Violations of Breach of Ethics

Any allegations of breach of ethics or violation of the Medical Staff Bylaws, or duly adopted rules, regulations, policies and procedures of the Medical Staff, shall be presented in writing to the MEC by any Medical Staff member, allied health professional, the Healthcare Administrator or administrative officer.
SECTION 2. Disciplinary Measures

When warranted, disciplinary measures shall be recommended by the MEC to the full Medical Staff within ten (10) days of the receipt of such allegations or within ten (10) days after the completion of investigation and processing of such allegations under established rules, regulations, policies or procedures, whichever is last, but in no case shall the entire process last longer than twenty (20) days.

SECTION 3. Action on Disciplinary Recommendations

The Medical Staff as a whole shall act on the recommendations made by the MEC within such time as determined by the Medical Staff, appropriate to the seriousness of the non-compliance or violation, but in no case more than fifteen (15) days after receipt of the recommendations of the MEC.

Subsection A. When loss, suspension or limitation of Healthcare privileges is recommended, the practitioner shall be entitled to the hearing and appeal rights set forth in ARTICLE III, SECTION 8.

Subsection B. Those recommendations not involving loss of Healthcare clinical privileges may be one or more, but not limited to, the following:

1. Reduction to Associate Medical Staff status.
2. Monitoring of patient care by an appointed committee or individual.
3. Retrospective monitoring of charts.
4. Written warning.

SECTION 4. Precautionary Restriction Or Suspension:

Criteria For Initiation

1. Whenever a member’s conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any person, or when medical staff leaders and CEO determine that there is a need to carefully consider any event, concern or issue which, if confirmed, has the potential to effect patient or employee safety, the effective operation of the institution, or to impair the reputation of the medical staff or institution then the CEO, the president of the medical staff, VPMA, the MEC, or the clinical service chief in which the member is assigned may restrict or suspend the medical staff membership or clinical privileges of such member as a precaution. Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the member, the MEC, the CEO and the governing board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the member’s patients shall be promptly assigned to another member by the clinical service chief or by the president of the medical staff, considering where feasible, the wishes of the effected practitioner and patient in the choice of a substitute member.

Medical MEC Action:

2. As soon as practicable after such precautionary restriction or suspension has been imposed, a
meeting of the MEC shall be convened to review and consider the action and if necessary begin the investigation process as noted in section 2.3. Upon request, the member may attend this meeting at the discretion of the MEC and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the member, constitute a “hearing” within the meaning defined in the hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the member with notice of its decision.

Procedural Rights

3. Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of the investigation described in section 2.3, the member shall be entitled to the procedural rights afforded by the hearing and appeal plan once the restrictions or suspension last more than 14 days.

SECTION 5. Disciplinary Suspension

The MEC may, with approval of the CEO, institute one or more disciplinary suspensions of a member for a cumulative period not to exceed 14 consecutive days in a calendar year. A disciplinary suspension may be instituted only under the following circumstances:

a) When the action that has given rise to the suspension relates to one of the following policies of the medical staff: completion of medical records, practitioner behavior (or disruptive practitioner policy) or requirements for the emergency coverage.

b) When the action(s) have been reviewed by the MEC and only when the MEC has determined that one or more of the above policies has been violated.

c) When the practitioner has received at least two written warnings within the last 12 months regarding the conduct in question. Such warnings must state the conduct or behavior that is questioned and specify or refer to the applicable policy, and state the consequence of repeat violation of the policy.

d) When the affected practitioner has been offered an opportunity to meet with the MEC prior to the imposition of the disciplinary suspension. Failure on the part of the practitioner to accept the MEC offer of a meeting will constitute a violation of the medical staff bylaws regarding “special meetings” and will not prevent the MEC from issuing the disciplinary suspension.

*NOTE: Issuance of a disciplinary suspension will not trigger the provisions of the Fair Hearing and Appeals Policy.*

Disciplinary Suspension and provision for coverage of existing hospitalized patients

a) A disciplinary suspension will take effect after the practitioner has been given an opportunity to either arrange for his or her patients currently at the medical center to be cared for by another qualified practitioner or until he/she has had an opportunity to provide needed care prior to discharge. During this period, the practitioner will not be permitted to schedule any elective admissions, surgeries, or procedures.

b) The president of the medical staff and the clinical service chief will determine the details of the

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extent to which the practitioner may continue to be involved with hospitalized patients prior to the effective date of the disciplinary suspension.

SECTION 6. Summary Suspension

Whenever a practitioner's conduct requires that immediate action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Healthcare, the President of the Medical Staff and the Administrator of the Healthcare, or their designated representatives, shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of such practitioner.

Such summary suspension shall become effective immediately upon imposition, and the Administrator shall promptly give special notice of the suspension to the practitioner. In the event of any such suspension, the practitioner's patients then in the Healthcare whose treatment by such practitioner is terminated by the summary suspension shall be assigned to another practitioner by the President of the Medical Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

As soon as possible after such summary suspension, but no longer than five (5) days following such suspension, the President of the Medical Staff shall call a meeting of the Medical MEC to review and consider the action taken. The MEC may modify, continue or terminate the terms of the summary suspension by majority vote. Unless the MEC immediately following such review and consideration terminates the suspension and ceases all further corrective action, the practitioner shall be entitled to the procedural hearing and appeal rights set forth in ARTICLE III, SECTION 8.

If the action of the MEC is to terminate the suspension and to cease all further corrective action, such action shall be transmitted immediately, together with all supporting documentation, to the Board for approval in accordance with ARTICLE III, SECTION 8.

ARTICLE XI

DISCIPLINARY ACTIONS

Should any disciplinary action or action to revoke, suspend or limit the privileges of any Medical Staff member or such investigation of a Medical Staff member under the rules, regulations, policies and procedures of the Medical Staff be undertaken, such Medical Staff member shall be ineligible to participate as a member of the Medical Staff or any Medical Staff committees in such investigation or in the consideration of action taken or to be taken by the Medical Staff or committee. The President of the Medical Staff shall appoint an interim replacement for such Medical Staff member on any committee on which the Medical Staff member serves which is charged with such investigation or consideration and such interim replacement shall serve until the investigation or consideration is terminated.

ARTICLE XII

AMENDMENTS

These Bylaws may be amended after notice given at any regular meeting of the Active Medical Staff. Such notice shall be laid on the table until the next regular meeting and two-thirds (2/3) majority of those present shall be required for adoption. Amendments so made shall be effective when approved by the Board.

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ARTICLE XIII
ADOPTION

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the Board of the Healthcare. They shall, when adopted and approved, be equally binding on the Board and the Medical Staff.

REVIEWED by the Active Medical Staff on 10/10/12

REVIEWED by the Board of Directors on 10/26/12

Holy Rosary Healthcare

MEDICAL STAFF RULES AND REGULATIONS

General

1. The regular meeting of the Medical Staff shall be held every month unless waived by the President of the Medical Staff.

2. Physicians admitting private patients shall be held responsible for giving information as may be necessary to assure the protection of other patients from those who are a source of danger.

3. All orders for treatment shall be in writing. Verbal orders shall be considered to be in writing if dictated by a practitioner or his/her designated representative. Verbal orders can be accepted by providers within the scope of their expertise. The orders must be signed by the person to who dictated with the name of the practitioner per his/her own name. Such orders shall be signed by the practitioner within 48 hours. Verbal NO CODE orders and verbal restraint orders must be signed by the practitioner within 24-hours. Such orders must be signed immediately by the person to who dictated and signed by the practitioner within twenty-four (24) hours.

4. All medical records, including x-rays, are the property of the Healthcare and shall be removed from the Healthcare's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. X-rays may be removed from the Healthcare for examination by a physician with written authorization from the Radiology Department. In case of readmission of a patient, all previous records available shall be provided for the use of the attending physician. (This shall apply whether the patient is attended by the same physician or other.)

5. Consultations
   A. Required Consultations

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Except in emergency, consultation with another qualified physician is required in:

1. Curettage's or other procedures by which a pregnancy may be interrupted.

   The following cases shall be exempt from the above rule:

   a. Diagnostic dilatation and curettage’s performed within two weeks of the last menstrual period.
   b. Postmenopausal patients.
   c. Whenever definite evidence of incomplete abortions is present.

2. Cases in which according to the judgment of the physician:

   a. The patient is an unusually poor risk.
   b. The diagnosis is unusually obscure.
   c. There is unusual doubt as to the best course of procedure with full consideration being given at the time, age of patient and circumstances.

3. Psychiatric consultation, when available, for the patient on all attempted suicides shall be offered to the patient or legal guardian and so documented on the patient's chart.

   B. A satisfactory consultation includes examination of the patient, the record and a written opinion signed by the consultant which is made part of the record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

6. Unless otherwise specified, only physicians shall admit patients suffering from all types of diseases. Admitting orders must include an admitting diagnosis. Patients admitted through the emergency department must be seen by their attending physician in a timely manner. Patients with emotional illnesses or chemical dependency-related disorders identified upon admission or that develop during the hospital stay will receive intervention and treatment by appropriate referral/consultation to outside agencies. Patients requiring transfer to other facilities for specialized treatment needs will be identified by the attending physician, hospital staff involved in the patient care and appropriate outside agency consultants. While on ICU status, patients will be seen on a daily basis by an Associate/Active Staff physician and within a timely manner of admission.

   a. All other patients admitted to the inpatient area other than the ICU shall be seen by their attending physician or other designated physician within a timely manner of admission and daily thereafter.

   b. Whenever a hospitalized patient's care is transferred to another practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A current progress note or verbal statement summarizing the patient’s condition shall be available to the accepting provider.

7. All drug orders for narcotics shall be discontinued after four (4) days and all drug orders for sedatives, hypnotics, anticoagulants and antibiotics (oral or parenteral) shall be discontinued after seven (7) days unless (1) the order indicates an exact number of doses to be administered, (2) an exact period of time for the medication is specified, or (3) the attending physician re-orders the medication. Notification of “Outdated Medications” shall be stamped on the Physician Order sheet.

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The nurse shall write the name of the medication outdated. Red tape shall be put on the front chart cover as sufficient notification of outdated medication. To be a valid order, the outdated medication order must be signed and dated by a practitioner; otherwise a nurse must obtain an order from a practitioner for the patient to continue the medication.

8. Each member of the Courtesy Medical Staff, not a resident in the city or immediate vicinity, shall name a member of the Active Medical Staff who is a resident of the city, who may be called to attend his patients in an emergency. In case of failure to name such an associate, the Administrator of the Healthcare shall contact the President of the Medical Staff to arrange for an Active Medical Staff member to attend the patient.

9. Patients shall be admitted and discharged only upon order of the attending physician or appointed designee. The record will be reviewed and cosigned by the attending physician if written by the appointed designee. The attending physician shall be held responsible for the preparation of a medical record for the Healthcare files. This record shall include identification data including Name, DOB, and Medical Record Number. The elements of the History and Physical should include: History of Present Illness, Past Medical History, Past Surgical History, Medications, Allergies, Social History, Family History, Review of Systems, Vital Signs, Physical Exam, and pertinent laboratory and radiology studies. The details and depth of each section should be adequate to provide quality care and assure patient safety. The record shall further include special reports, consultations, medical and surgical treatment, progress notes and discharge summary.

Authentication of Records – All entries must be complete, legible, written in English and authenticated, dated and timed promptly by the author. The following records may be authenticated either by written signature, electronic signature or computer key:

1) History and physical examinations;
2) Progress notes;
3) Physician orders
4) Consultations;
5) Operative reports/procedures; and
6) Discharge summaries.

When computer signing is authorized and used, the individual whose signature the computer key represents sign a statement that he/she alone possesses and will use such code.

Any documentation entry that may be dictated or hand written may be electronically entered in the medical record instead of being dictated or hand written, subject to the authentication and other requirements for electronic records under applicable HRH policies and state and federal law.

No medical record shall be filed until it is complete.

10. History and physical shall be completed promptly within twenty-four (24) hours after admission of the patient. Except in an emergency, the history and physical examination shall be written or dictated prior to the operation. This is not applicable to outpatients under local anesthesia.

11. Patient charts shall be completed within thirty (30) days after discharge of the patient. Quality Improvement charts shall be completed within thirty (30) days after submission. Physicians who have not completed charts within the thirty (30) day limit will be notified in writing by the Medical Records Department Manager that admitting privileges will be suspended if the incomplete charts are not completed within fifteen (15) days from notification subject to approval of the MEC. If, after thirty (30) days after notification, the physician is still in violation, this physician shall be in violation of
ARTICLE IX of the Bylaws and immediate action under this Bylaw Article will be instituted.

12. Every member of the Medical Staff shall be actively interested in securing autopsies whenever possible, especially in deaths following or during surgery, pediatric deaths, deaths related to childbirth and unexpected deaths. No autopsy shall be performed without written consent of the responsible relative or relatives. All autopsies shall be performed by the Healthcare pathologist or by a physician to whom he may delegate the duty. The provisional autopsy shall be completed within 72 hours, and the final autopsy report is due in 60 days.

13. Rules and regulations of the Montana State Board of Health regarding communicable and other reportable diseases, copies of which are available in the nurse's station, shall be observed in all departments of the Healthcare.

14. Medical Staff Disaster Assignments:

All physicians shall be assigned to duties, either in the Healthcare, the auxiliary Healthcare, or in a mobile casualty station and it is their responsibility to report to their assigned stations. The Medical Disaster Chairperson in the Healthcare and the Administrator of the Healthcare will work as a team to coordinate activities and directions. In case of evacuation of patients from one section of the Healthcare to another or evacuation from Healthcare premises, the Medical Disaster Chairperson during the disaster will authorize the movement of patients by direction of the Administrator of the Healthcare. All policies concerning patient care will be the joint responsibility of the Medical Disaster Chairperson and the Administrator of the Healthcare, and in their absence their designees and an alternate in administration are the next in line of authority respectively. All physicians on the Medical Staff of the Healthcare are specifically to relinquish direction of the professional care of their patients, service and private, to the Medical Disaster Chairperson in cases of such emergency.

15. The discharge summary may serve as a postoperative note and/or progress note on those patients who are dismissed within 48 hours of the time of admission.

16. Allied Health Professional may not initiate patient contact on an inpatient without the attending physician's consent... However, in the case of an emergency, contact may be initiated.

17. The Medical Staff of Holy Rosary Healthcare shall use a specialty type of Emergency Room back up with each specialty responsible for setting up coverage within that discipline. An Allied Health Professional may be designated first call with physician back up available.

18. The Emergency Department Services are provided by Holy Rosary Healthcare.

The policy of Holy Rosary Healthcare’s Emergency Department is to examine, treat and refer for office follow-up, as necessary, all patients seen in the Emergency Department (except for those needing specialty care e.g. antibiotics, scheduled treatments, dressing changes.) All patients presenting for care in the Emergency Department, except for those needing specialty care, will have a medical screening exam completed by a Medical Practitioner and/or Physician. Obstetric patients may receive their medical screening exam by qualified OB nursing staff with consultation by a physician. Referral (office follow-up) to the personal physician or appropriate physician on call is made. A copy of the Emergency Record is forwarded to the patient’s Medical Practitioner of choice.

19. Medical Staff Emergency Department Call Responsibilities

Members of the Associate, Active and Temporary Staff categories shall serve on the Emergency Rotating Call Roster for hospital admission and consults. The exception is the full Medical Staff may
vote to relieve any Active Medical staff member of Emergency Rotating Call duties when attaining the age of 60 (or if it deems desirable for health reasons prior to this age).

A monthly call roster that contains the names of physician’s on call, assigned on a rotational basis, will be published and distributed by designated hospital personnel. The call roster will be maintained for 5 years.

Should the on-call physician fail to fulfill any of these responsibilities or obligations, such failure shall be reported to the MEC. Upon receipt of any report, the MEC shall investigate any alleged failure of the on-call physician to fulfill her/her obligation and within 15 days submit a written report of the investigation to the President of the Medical Staff.

20. Patient Transfer Guidelines

If the on-call physician recommends the transfer of a patient without examining the patient himself/herself and the Medical Practitioner covering the Emergency Department considers the transfer inappropriate, the following steps are to be followed:

a) The Medical Practitioner covering the Emergency Department will so state to the on-call physician and ask that the physician come in to evaluate the patient in person.

b) If the above is unsuccessful, the Medical Practitioner covering the Emergency Department will proceed with the following steps:
   a. Consult the President of the Medical Staff.
   b. If the President of the Medical Staff is not available, the Vice President, Secretary, Past President or Chairperson of the Emergency Committee should be contacted.

All transfers are to be in accordance with Holy Rosary Healthcare’s Patient Transfer Policy and the physician portion of the Patient’s Request/Refusal Consent to Transfer Form is to be completed and signed.

21. Perform or provide History and Physicals

a. If the admitting practitioner or appropriate designee has performed a history and physical examination within 30 days of admission, or any surgery, a durable, legible copy of this report may be used in the patient’s medical record in lieu of a new history and physical.

b. If the examination is recorded within the 30 days prior admission, an updated medical record entry documenting an examination for any changes in the patient’s condition is complete and in the patient’s medical record within 24 hours after admission, or before surgery.

22. Arterial blood gas drawing may be done by qualified technical personnel according to the discretion of the Healthcare pathologist or attending physician.

23. Licensed physicians and allied health professionals (AHP) may order tests and therapy services. If an out-of-state physician or AHP is ordering tests or therapy services, each department will have a guideline in order to assure that the patient receives appropriate care. Only physicians or AHP credentialed at HRH may order administration of medication or chemotherapy, or order invasive or risky procedures that would require patient consent. Examples of this include, but are not limited to, surgery, invasive radiologic procedures, EGD, colonoscopy and cardiac stress testing.

24. All categories of the Medical Staff and Allied Health Professionals, except Honorary Staff, will show proof of at least $1,000,000 malpractice insurance. All categories will be covered through an

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insurance carrier approved by the State of Montana.

25. The emergency department/services offer emergency care 24 hours a day with at least one physician available to the emergency care area within approximately 30 minutes through a Medical Staff call roster.

33. All members of Holy Rosary Healthcare’s Medical Staff are required to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

34. Surgical Monitoring of Associate Staff

The purpose of surgical monitoring is to provide evaluation of new surgeons applying for Associate Staff privileges at Holy Rosary Healthcare.

This policy is implemented in the surgery department (including anesthesia and endoscopy) requiring a physician’s initial six (6) cases of different organ systems or parts of the body be observed by a physician in the same specialty or with comparable privileges on the current Active Staff. If no physician is available on the current Active Staff, or the candidate wishes outside proctorship, the hospital is responsible for obtaining monitoring from an affiliate hospital.

1. This procedure and an agreement to participate in the proctorship program will be sent to any new applicant who will request surgical privileges.

2. The Chairperson of the Surgery & Anesthesia Committee will identify the six initial cases to be proctored.

3. The procedure review form will be completed by the Chair of the Surgery & Anesthesia Committee and Associate Staff candidate and forwarded to the Medical Staff Coordinator.

4. After completion of the form following the proctorship, the form will kept in the physician’s professional file for review when considering Active Staff membership.

(NOTE: This does not apply to Courtesy Staff because according to Section 4, Subsection B of the Medical Staff Bylaws states, “Members of the Courtesy Medical Staff shall be under the direct supervision of a physician.”)

28. Protocol for Dealing with the Chemically Dependent Self-Referred Physician

PURPOSE: To evaluate and treat chemical dependence in a confidential but effective environment that will allow early return to work where possible.

SCOPE: All self-referred physicians and allied health professionals with a problem of chemical dependency.

POLICY: All self-referred physicians and allied health professionals with chemical dependency will be evaluated, treated, and returned to work under the guidelines of the MEC as outlined in the Medical Staff Bylaws of Holy Rosary Healthcare.

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 RESPONSIBLE PERSON: Members of the MEC.

PROCEDURES:

1. Upon initial contact, an appointment is to be arranged at the earliest possible time between the physician and the MEC. The purpose of this meeting will be:
   a. To explain the role, the policies and the purpose of the MEC.
   b. To conduct an intake evaluation/interview.

2. The MEC shall, during such investigation, referral and treatment, suspend, curtail or place conditions upon the Medical Staff privileges of the physician as it deems necessary for the protection of patients and for assurance of the quality of health care. In making of such determination by the MEC, the physician shall have all due process rights existing under the medical Staff Bylaws of the Medical Staff.

3. After the intake evaluation/interview, a preliminary treatment plan will be developed by the MEC. The expense of this treatment plan shall be the responsibility of the practitioner. This initial plan may include any or all of the following:
   a. Physical evaluation
   b. Psychiatric evaluation
   c. Inpatient or outpatient detoxification
   d. Residential rehabilitation
   e. Outpatient rehabilitation
   f. Individual/group therapy
   g. Alcoholics Anonymous/Narcotics Anonymous
   h. Physician Support Group
   i. Additional supportive services.

4. If an initial treatment phase is required, the client will enter the ongoing monitoring phase of the Program upon completion of initial treatment.

5. Re-entry Conference - Re-entry may involve any or all of the following:
   a. Limited work/call schedule.
   b. Urine testing, according to rule #32.
   c. Signing of a written agreement on "contract".
   d. Reporting and updating with the State Board according to current Board of Medical Examiner's requirements.
   e. Documented attendance at Alcoholics Anonymous/ Narcotics Anonymous meetings as well as aftercare.
   f. Marriage and/or family therapy.
   g. Individual counseling.

6. Monitoring parameters will be in place for two (2) years minimum.

7. All activities in regard to such cases shall be treated with the utmost confidence. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such allegations or incidents to appropriate regulatory agencies, insurers, or
36. **Protocol for the Management of Non-Self-Referred Physician Alleged to be Impaired by Substance Abuse**

**PURPOSE:** Substance abuse by a physician potentially seriously jeopardizes the quality of care for Healthcare patients and poses a significant risk of harm to the patient and attendant liability exposure to the Healthcare. Due to the on-call status of Medical Staff physicians, such substance abuse, although not occurring while actually working in the Healthcare, interferes with the practice of medicine and presents a risk of interference with patient care or availability of the physician to be involved in patient care.

**SCOPE:** Any member of the Healthcare Medical Staff or Allied Health Professional.

**POLICY:** Cases of suspected substance abuse will be reported to the Administrator in writing and investigated by the MEC. Opportunity will be given for the Medical Staff member to self-refer for appropriate treatment. If the Medical Staff member declines or neglects to self-refer, appropriate treatment will be offered, and, if accepted, will be instituted. Medical Staff privileges will be suspended or curtailed as deemed necessary by the MEC pending the completion of such treatment. Upon successful completion of treatment, if possible, the physician will return to work under the guidelines of the MEC as outlined in the Medical Staff Bylaws of Holy Rosary Healthcare.

**RESPONSIBLE PERSON:** Members of the MEC.

**PROCEDURES:**

1. Careful documentation of the allegations.
   
   a. Interview of the physician, health care staff, spouse and/or family in regard to behaviors indicative of substance abuse.
   
   b. Interview of professional associates as to behaviors indicative of substance abuse.
   
   c. Interview of other persons having knowledge or information pertinent to behaviors indicative of substance abuse.

2. If a physician comes to the attention of the medical community or Healthcare Administrator because of indications of substance abuse, the MEC shall investigate. The MEC shall inform the Healthcare administration of such investigation and the results of these procedures.

3. When it is suspected that substance abuse is occurring with a physician, the physician should be personally interviewed by two (2) members of the MEC, preferably one of which has expertise in the diagnosis and treatment of substance abuse.

4. In the absence of reasonable grounds to believe that substance abuse by the physician is present, the case will be closed.

5. If, following such investigation, there are reasonable grounds to believe that substance abuse by the physician is present; the following steps will be
followed:

a. The physician will be informed in writing by the MEC of the basis upon which a determination of reasonable cause was made.

b. The physician will be offered an opportunity to self-refer for appropriate treatment within five (5) days of the date of notification of the determination of reasonable cause. If he does self-refer, the procedures for dealing with chemically dependent self-referred physicians shall be followed.

c. Should the physician decline or neglect to self-refer within such five (5) day period, he shall be requested by the MEC to submit to professional evaluation by a professional health care provider experienced in the evaluation of substance abuse, such professional to be selected by the MEC.

d. Should the physician not promptly honor such request, the matter shall be referred to the MEC of the Medical Staff for appropriate action. The physician shall have all due process rights existing under the Bylaws of the Medical Staff.

e. Should the physician honor the request and the professional evaluator determine that substance abuse is not indicated, the matter shall be closed.

f. Should the physician honor the request and the professional evaluator determine that substance abuse is indicated, then a plan of treatment shall be formulated and presented to the physician.

g. Should the physician decline to accept and undertake the plan of treatment, then the matter shall be referred to the MEC for appropriate action. The physician shall have all due process rights existing under the Bylaws of the Medical Staff.

h. Should the physician accept and undertake the plan of treatment, such treatment shall be at the expense of the physician with the substance abuse problem. The physician shall supply to the MEC such reports of the progress or results of treatment as the MEC shall deem necessary.

i. The MEC shall, during such investigation, referral and treatment, suspend, curtail or place conditions upon the Medical Staff privileges of the physician as it deems necessary for the protection of patients and for assurance of the quality of health care. In the making of such determination by the MEC, the physician shall have all due process rights existing under the Medical Staff Bylaws of the Medical Staff.

j. Following completion of the established plan of treatment, the physician may apply to the MEC for reinstatement of full Medical Staff privileges or the elimination or modification of any conditions imposed upon such privileges.
6. All activities in regard to such cases shall be treated with the utmost confidence. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such allegations or incidents to appropriate regulatory agencies, insurers, or Healthcare administration.

30. **Confrontation of Physician Alleged to be Chemically Impaired While Working in the Healthcare**

**PURPOSE:** In order to assure the highest quality of patient care, any physician or allied health professional alleged to be working in the Healthcare under the influence of any chemicals or impaired in any other way should be confronted by the Chairperson of the Department and/or the President of the Medical Staff or his/her designee. The goals are to get the involved individual out of the patient care setting and assure continuity of patient care by arranging appropriate coverage for that physician's or professional's patient(s).

**SCOPE:** Any member of the Healthcare medical or allied health professional staff.

**POLICY:** In the event a physician or allied health professional should appear at the Healthcare with the intention of directly or indirectly participating in patient care, and in the opinion of a member(s) of the Healthcare Medical Staff, fellow physician or professional appears to be impaired in the capacity to perform patient care, then appropriate individuals will be notified to interrupt the patient care activity, request the offending physician or professional to leave the Healthcare, and arrange for appropriate coverage for continuity of patient care.

**RESPONSIBLE PERSON:** President of the Medical Staff and/or his personal designee; Members of the MEC.

**PROCEDURES:**

1. The President of the Medical Staff or the Administrator will be asked to come to the Healthcare and meet with the physician in question. They will assess the physicians or professional's activity and degree of impairment if appropriate.

2. If in their opinion any question of impairment and/or intoxication exists, a urine sample should be immediately obtained under the direct supervision of a designated staff physician. This urine will be subsequently evaluated for mood altering substances. Blood alcohol may also be requested, according to rule #32.

3. Failure of the affected physician or professional to comply with the requested evaluation by a peer or body fluid samples under these circumstances shall be referred directly to the MEC for possible disciplinary action. If patient care is in jeopardy, then the President of the Medical Staff may utilize appropriate sections of the Bylaws to temporarily suspend Healthcare privileges of the offending physician.

4. Following the clinical and evaluation and possible assessment of body fluids, the involved individual will be sent home and appropriate coverage will be
arranged by the President of the Medical Staff and/or his designee.

5. The incident should be appropriately documented by all individuals involved. This information should be referred immediately to the MEC along with any laboratory studies, as soon as possible.

6. All activities in regard to such cases shall be treated with the utmost confidence. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such allegations or incidents to appropriate regulatory agencies, insurers, or Healthcare administration.

31. The following procedures shall be followed for body fluid sampling as referenced in these Bylaws and Rules & Regulations.
   a. Collection of blood or urine in a manner that minimizes invasion of personal privacy while ensuring the integrity of the sample.
   b. Collection of a sample sufficient to administer several tests.
   c. Collection and storage in tamper-proof containers.
   d. Adoption of a chain-of-custody documentation procedure.
   e. Verification of results by two independent testing procedures.
   f. Prohibition of the release of results except as authorized by the person tested or required by a court of law.
   g. Provision of the test results to the person tested.
   h. Provision of an opportunity for the person tested, at their own expense, to obtain a confirmatory test at an independent laboratory of their own choosing.
   i. Provision of an opportunity for the person tested to rebut the results of the tests.

32. Evaluation of Medical Staff Applicants with a History of Alcohol/Drug Impairment

PURPOSE: When physician and allied health professional applicants to the Healthcare staff have a history of drug and/or alcohol impairment or psychiatric impairment, some formal evaluation may be necessary as a part of the credentialing process. The purpose of this policy is to provide a format whereby such recovering physicians and professionals can demonstrate their recovery in a confidential setting. Once the recovering process has been identified by the Credentials Committee, monitoring parameters can be established if needed, in the opinion of the Credentials Committee.

SCOPE: The policy will apply to all new physician applicants or reappointments to the Medical Staff. Paramedical personnel are encouraged to seek guidance through the Employee Assistance Program.

POLICY: All applicants to the Medical Staff, who have a history of chemical or mental impairment, will be reviewed by the Credentials Committee as a part of the credentialing process.

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RESPONSIBLE PERSON: Members of the Credentials Committee.

PROCEDURES:
1. The Credentials Committee will review all available information regarding the recovery program of the applicant.

2. The Credentials Committee will meet with the applicant for an informal discussion of his illness and recovery program.

3. Based on the information collected and the review by the Credentials Committee, a recommendation will be made to the MEC regarding granting of Medical Staff privileges.

4. In the event of an adverse recommendation by the Credentials Committee, a full disclosure of the information at hand must be made to the MEC in support of that adverse recommendation. The affected practitioner is assured due process according to the Bylaws.

5. If a favorable recommendation is made to the MEC regarding the applicant, the MEC will decide what, if any, monitoring will be done, and whether or not a numbered file will be opened.

6. All activities in regard to such cases shall be treated with the utmost confidence. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such allegations or incidents to appropriate regulatory agencies, insurers, or Healthcare administration.

33. Protocol for the Management of Physician Alleged to be Impaired by Compulsive Gambling

PURPOSE: As compulsive gambling is a silent condition without obvious physical or behavioral manifestation until the individual has created a financial problem of such severity that it interferes with the practice of medicine, the following protocol is recommended.

SCOPE: Any member of the Healthcare medical or allied health staff.

POLICY: Cases of suspected compulsive gambling will be reported in writing to and investigated by the MEC. Appropriate treatment will be instituted and whenever possible, the physician will return to work under the guidelines of the MEC as outlined in the Medical Staff Bylaws of Holy Rosary Healthcare.

RESPONSIBLE PERSON: Members of the MEC.

PROCEDURES:
1. Careful documentation of the allegations.
   a. Interview the spouse and/or family in regard to finances and behaviors indicative of gambling.
   b. Interview of professional associates as to behaviors indicative of
2. If a physician or allied health professional comes to the attention of the medical community because of criminal indictment for financial malfeasance, compulsive gambling should be suspected and the MEC should investigate.

3. When it is suspected that an individual's problem creating the impairment is compulsive gambling, the individual should be personally interviewed by two (2) members of the MEC.

4. In the absence of positive confirmation, the case will be closed. If there is positive confirmation of the allegations, the following steps will be followed:
   a. Referral will be made to a psychiatrist experienced in evaluating individuals with this problem to determine whether any other psychiatric condition exists concomitant with compulsive gambling.
   b. On the psychiatrist's recommendation, the individual will submit to either:
      1) An inpatient rehabilitation gambling program;
      2) Gamblers Anonymous enrollment and evidence of participation;
      3) If indicated, psychiatric treatment appropriate for the diagnosable psychiatric condition.

5. The individual with the problem is responsible for the payment of costs for any recommended treatment.

6. Whatever modality of treatment is employed, reports from the participating therapist or facility indicating compliance will be necessary before the MEC deals with re-entry problems of the physician/professional patient.

7. If the physician refuses to cooperate with the recommendations, the case will be reviewed by the MEC for appropriate action.

8. All activities in regard to a case will be treated with the utmost confidence. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such allegations or incidents to appropriate regulatory agencies, insurers or Healthcare administration.

34. Management of Physicians with Physical Disabilities that Produce Impairment of Professional Performance

PURPOSE: These guidelines are established for a fair and impartial evaluation of impairment for physicians and allied health professionals when a disability is present.

SCOPE: This evaluation can be instituted at the request of any members of the Medical Staff, the MEC or the Healthcare Administrator.

POLICY: The Credentials Committee shall evaluate any and all instances of purported
impairment secondary to a physical disability in a confidential and humanitarian manner as outlined in this protocol.

RESPONSIBLE PERSON: Members of the Credentials Committee.

PROCEDURES:
1. Careful documentation of the impaired performance must be made.

2. The physician or professional will personally be visited by a team composed of:
   a. A member of the Credentials Committee; and
   c. The personal physician of the individual being evaluated; and
   c. An appropriate specialist, if available.

The purpose of this visit is to evaluate the person in terms of:
   a. The limitations imposed by the disability; and
   b. Possible ways to overcome these limitations; and
   c. The ability to practice medicine or perform professional activities in any setting.

3. If there are unresolved questions as to physical, emotional or neurological status, additional examinations and/or appropriate studies may be recommended.

4. The visiting team will report their final findings to the entire Credentials Committee along with recommendations for appropriate action, if any. The expense of any treatment plan shall be the responsibility of the practitioner.

5. The Credentials Committee will review the report and the recommendation of the visiting team and decide on further action, if required. The affected practitioner is assured due process according to the Bylaws.

6. It is the policy of the Staff that no member shall be discriminated against on the basis of mental or physical handicap unless the reasonable demands of the position require such discrimination. If the decision of the Credentials Committee is to limit the physician's privileges in any way, a written, documented finding that the impairment unduly interferes with the reasonable demands of the position of the practitioner must be forwarded to the MEC for approval and final action.

7. In cases where a prompt decision is required, a conference call with the Chairperson of the Credentials Committee and the evaluation team may be employed in place of a full meeting of the Credentials Committee. If a need to limit privileges arises on an emergency basis out of this conference call, the deliberations will include the President of the Medical Staff.

8. All activities in regard to such cases shall be treated with the utmost confidence. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such
allegations or incidents to appropriate regulatory agencies, insurers, or Healthcare administration.

35. Guidelines for Assisting Physicians Experiencing Impairment of Professional Performance Because of Mental/Emotional Disturbances

PURPOSE: To achieve a fair and impartial assessment of impairment of a physician or allied health professional associated with a mental/emotional disturbance and to assist the affected individual in initiating and continuing appropriate treatment for his condition.

SCOPE: Action may be instituted at the request of the MEC, the Healthcare Administrator, or any member of the Medical Staff.

POLICY: The MEC shall assess any and all instances of purported impairment associated with mental/emotional disturbances in a manner at once confidential, humanitarian, and directed toward assisting the affected individual.

RESPONSIBLE PERSON: Members of the MEC.

PROCEDURES:
1. Careful documentation of the situation of alleged impaired performance must be made.

2. The physician or professional will be visited personally by a team composed of:
   a. A non-psychiatric member the MEC; and
   b. A psychiatric member of the Executive Committee, if available; and
   c. The personal physician or psychiatrist treating the physician or professional may be included as a member of the team if he agrees to participate and it is deemed appropriate by the Chairperson of the Committee.

   The purpose of this visit(s) is to:
   a. Apprise the individual of the observations of impaired performance that have been reported;
   b. Assess the individual's mental status, insight, and willingness to seek appropriate help;
   c. Offer assistance in making arrangements for appropriate care and treatment; and
   d. Determine if some limitation of privileges should be imposed until such improvement in the person's condition has been achieved.

3. If the team deems it prudent and necessary to do so, they may consult with the person's family and/or request physical, neurological, laboratory, and/or psychological consultations or examinations to clarify the nature of the problem.

4. The visiting team shall report its findings and actions to the full Executive Committee. This report shall include only as much detail as is necessary for the MEC to appreciate and concur with or alter the actions of the team or to
participate in further decision-making regarding the situation, if it be unresolved.

5. In response to the report of the team the MEC may require that the physician or professional undertake treatment for his mental/emotional disturbance and follow the recommendations of the treating psychiatrist, may recommend limitations of the physician's or professional's privileges, and may take other actions which it deems appropriate to the situation. The expense of any treatment plan shall be the responsibility of the practitioner.

6. If the decision of the MEC is to limit the physician's or professional's privileges in any way, that recommendation must be forwarded to the MEC of the Medical Staff for approval and final action. The affected practitioner is assured due process according to the Bylaws.

7. In cases where a prompt decision is required, a conference call with the President of the Medical Staff and the visiting team may be employed in place of a full meeting of the MEC.

8. Once treatment of an individual for mental/emotional disturbance is instituted, the treating psychiatrist will be asked to keep the MEC informed that the treatment is or is not continuing satisfactorily, as to the frequency of the contacts, and when the treatment has been successfully concluded by mutual agreement. Details as to the content of psychotherapy or as to medication need not be reported to the MEC.

9. The team may require the physician or professional to meet with them from time to time as they deem prudent and necessary to assess the individual's mental status, improvement, and ability to perform and care for patients in an unimpaired way. They may seek consultation from a non-treating psychiatrist, additional psychological testing or other data which they may feel they require to make these determinations.

10. All persons participating in these procedures are to be aware of the importance of utmost confidentiality. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such allegations or incidents to appropriate regulatory agencies, insurers or Healthcare administration.

11. When a physician or professional who is experiencing a mental/emotional disturbance which has not produced impairment of professional performance has obtained appropriate help voluntarily, he is under no obligation to inform the MEC and this protocol will not be operative in such a case. All persons involved in these deliberations should be aware that a physician or professional suffering a mental/ emotional disturbance does not necessarily imply that his professional performance is impaired.

36. Protocol for the Management of Physicians Accused of Sexual Misconduct

PURPOSE: Provide a confidential way of investigating alleged instances of sexual misconduct and instituting treatment where possible.

October 2012
SCOPE: Any member of the Healthcare medical or allied health professional staff.

POLICY: Any complaints from Healthcare employees, patients, or members of the Medical Staff of alleged sexual misconduct will be investigated according to this protocol.

RESPONSIBLE PERSON: Members of the MEC

PROCEDURES:
1. Careful documentation of the allegations must be made.

2. The physician or professional will be interviewed by one (1) or two (2) members of the MEC.

3. In the absence of positive confirmation, the case will be closed. If there is positive confirmation of the allegations, the following steps will be followed:
   a. The physician or professional will be requested to submit to a complete physical examination. A neurological examination, if it seems appropriate, may also be requested.
   b. The physician or professional will be referred for psychiatric evaluation to a psychiatrist approved by the MEC. A precise psychiatric diagnosis will be requested. (This may include the diagnosis of NO PSYCHIATRIC ILLNESS.)
   c. Following the completion of the evaluation, a formal diagnosis will be made, if possible. The psychiatrist will participate with the MEC members to facilitate an intervention or treatment plan based on the findings of the evaluation.
   d. Subsequent treatment will be based on the precise diagnosis.
   e. The physician or professional is responsible for the payment of the cost of treatment.
   f. If psychiatric therapy is appropriate, the physician or professional must agree to have periodic reports of the continuation of therapy submitted by the treating therapist to the MEC. These reports are only to establish that therapy is taking place and do not involve the issues discussed in treatment. Treatment may only be discontinued by the mutual consent of patient and therapist with notification to the MEC.

4. In the event the allegations are confirmed and the physician or professional refuses to cooperate in this therapeutic program at any point, the case shall be referred to the MEC for review and appropriate action. The affected practitioner is assured due process according to the Bylaws.

5. All activities in these cases will be treated with the utmost confidence. However, such requirement of confidentiality shall not interfere with any statutory, regulatory or contractual requirement of reporting such allegations.

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37. **Medical Staff Monitoring, Evaluation Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation**

**Purpose:** To ensure that the hospital, through the activities of physicians and allied health professionals (AHP), assesses the performance of individuals granted clinical privileges and uses the results of such assessments to improve care.

**Goals:**
1. Improve the quality of care provided by individual physicians and allied health professionals.
2. Monitor the performance of practitioners who have privileges.
3. Identify opportunities for performance improvement.
4. Monitor significant trends by analyzing aggregate data.
5. Assure that the process for peer review is clearly defined, fair, defensible, timely, useful, and communicated in a proactive manner.
6. Identify opportunities for recognition of excellence.

**Definitions:**

**Ongoing Professional Practice Evaluation**
Ongoing Professional Practice Evaluation (OPPE), formally known as peer review, is the evaluation of an individual practitioner’s professional performance and includes, but is not limited to, the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner’s performance, rather than appraising the quality of care rendered by a group of professionals or a system.

The information used in the ongoing professional practice evaluation may be acquired through the following:
- Ongoing data collection, especially as related to ongoing practice improvement activities
- Periodic chart review and/or case discussion(s)
- Direct observation

The individual’s evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of the professional, technical, and interpersonal skills in providing patient care.

**Focused Professional Practice Evaluation**
Focused Professional Practice Evaluation (FPPE) is the evaluation that focuses on specific aspects of an individual provider’s performance. Generally this occurs if questions arise during the course of the OPPE, or if further information is needed to assure provider competence.

**Peer**
A Peer is a fully licensed individual practitioner permitted by law to provide patient care services and has like clinical privileges. The level of subject matter expertise required to provide meaningful evaluation of a practitioner’s performance will be determined on a case-by-case basis. For example, review of the general medical care of a physician can be done by another physician, while review a sub-specialty clinical issue or surgical procedure will require a provider who is well-trained in that specialty. In certain situations external peer review may be utilized. The degree of subject matter expertise required for a provider to be considered a peer will be determined by the committee members performing peer review or, for specific circumstances, by the Medical Executive Committee.

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Conflict of Interest

A conflict of interest may exist if a member of the medical staff is not able to render an unbiased opinion. Automatic conflict of interest would result if the provider is the one under review. A relative conflict of interest may exist due to involvement in the patient’s care or because of a professional association or competition with the provider.

Policy:

1. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, as well as state and federal laws and regulations pertaining to confidentiality and non-disclosability.
2. The involved practitioner will receive provider specific feedback on a routine basis.
3. The hospital will use the provider-specific peer review results in its credentialing and privileging process and, as appropriate, in its performance improvement activities.
4. The hospital will keep provider-specific peer review and other quality information concerning a practitioner in a secure, locked file. Provider specific peer review information consists of information related to: a.) Performance data for all dimensions of performance measured for that individual professional. b.) The individual’s role in sentinel events or never events, significant incidents or near misses. c.) Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action.
5. Peer review information is available only to authorized individuals who a have a legitimate need to know this information, and they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. The following individuals shall have access to provider-specific peer review information and only for the purposes of quality improvement: a.) Members of the Executive Committee (MEC), Credential Committee and the Medical Staff Quality Improvement Committee; b.) Risk Management specialist; c.) Surveying or accrediting bodies with appropriate jurisdiction, i.e. The Joint Commission (TJC) or state/ federal regulatory bodies; d.) Individuals with a legitimate purpose for access as determined by the hospital board of directors; e.) The hospital CEO when information is needed to take immediate formal corrective action for the purposes of summary or precautionary suspension of the provider by the CEO.
6. No copies of peer review documents will be created and distributed.

Circumstances requiring peer review (OPPE):

1. Upon initial appointment of the physician or allied health professional, the Credentialing Committee will review a random selection of cases. Direct observation may also be appropriate.
2. Ongoing peer review done during appropriate committee meetings to include but not limited to, 2 charts and utilization data twice yearly.

Circumstances requiring external peer review:

1. Litigation, as directed by legal counsel.
2. Ambiguity when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees, and conclusions from the review will directly impact a practitioner’s membership or privileges.
3. Lack of internal expertise, either when there is no one on the medical staff that has adequate clinical experience in the case, or when the only practitioners on the medical staff with that expertise have a conflict of interest.
4. Miscellaneous issues such as the need for an expert witness for a fair hearing, for evaluation of a credential file, or assistance in developing a benchmark for quality monitoring. In addition, the MEC or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

The decision to request an external review is made by the MEC or governing board, and not by the individual provider.

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Circumstances requiring Focused Professional Practice Evaluation (FPPE):

1. A never event, sentinel event or “near miss” identified during concurrent or retrospective review.
2. Within a 12 month period of time, any one of the following criteria:
   - 2 cases rated “care inappropriate”
   - 3 cases rated either “care controversial or inappropriate”
   - 3 cases having documentation issues regardless of care rating
3. Any medical procedure that is new for the individual provider.
4. When a provider has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization’s setting.
5. An unusual individual case or clinical pattern of care identified during a quality review.
6. New appointments to the medical staff
7. Must be backed up by didactic outcomes measures or other defined indicators

The MEC shall appoint a panel of appropriate medical professionals to perform the necessary FPPE. This will be done in a timely manner with the goal to be completed within 90-120 days of the review, depending on the complexity of the case.

OPPE Procedure:

1. Relevant committees will select electronic cases/ charts for review by both physician and AHP.
2. Committees that will engage in OPPE include, but are not limited to, Medical P&T Committee, Surgery and Anesthesia Committee, Perinatal Committee, Credentials Committee and Emergency Committee.
3. All credentialed physicians and AHP will participate on one or more of these committees.
4. OPPE will be distributed at the committee meetings by the chair of the committee.
5. Each committee will review the OPPE sheet approved by the medical staff, and establish appropriate action plan for those reviews that are considered controversial or inappropriate, or have documentation problems.
6. The chart review, findings and action plan will be recorded and placed in the appropriate staff office.
7. If the finding is a circumstance requiring focused professional practice evaluation (FPPE) to include a never event, sentinel event or “near miss” identified during concurrent or retrospective review, or within a 12 month period of time, any one of the following criteria two cases rated “care inappropriate”, three cases rated either “care controversial or inappropriate” and/or three cases having documentation issues regardless of care rating the finding will be reported to the credentials committee in a timely manner. Otherwise the FPPE will be placed in the credentials committee for regular reappointment review.

FPPE Procedure:

1. The credential committee will identify those instances as outlined in the policy whereby a FPPE is required.
2. The credential committee will refer these to the MEC.
3. The MEC will appoint appropriate physicians or AHP to conduct a FPPE.
4. The results of the FPPE will be reported to the MEC.
5. The MEC will make recommendations for an action plan based on the findings of the appointed committee.
6. The results of the FPPE and the MEC recommendations will be maintained in the reviewed provider(s) credential file.
7. The MEC will report any on-going FPPE to the governing board.

References:
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1. Montana Annotated Code-Sections related to peer review (www.dataopi.state.mt.us/bills/mca_toc/33_37_1.htm)
2. JCAHO Sentinel Events Policy and Procedure (www.jointcommission.org/SentinelEvents/SentinelEventAlert/)

38. **Disruptive Behavior Involving Members of the Medical Staff**

**DEFINITIONS:**

“Harassment” means verbal or physical activity directed against any individual, e.g., against another medical staff member, house staff, hospital employee or patient, on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation.

“Member” or “medical staff member” is defined as an individual who has been granted medical staff membership or, although not a member, has been granted temporary or disaster privileges. The term does include medical students or residents, or allied health professionals with or without clinical privileges.

“Sexual harassment” is defined as unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

**PURPOSE:**

To promote patient safety and quality improvement through facilitating communication and cooperate among healthcare professionals by describing and prohibiting disruptive behavior involving medical staff members and delineating the response to be followed in all cases of allegations of disruptive behavior involving medical staff members. Disruptive behavior by members of the medical staff, or refusal of members to cooperate with the procedures described in the Policy, may result in corrective action, which shall be carried out according to the medical staff bylaws.

Disruptive behavior by members of the medical staff that affects or may affect patient care, or refusal of members to cooperate with the procedures described in this Policy, may result in corrective action, which shall be carried out according to the medical staff bylaws.

**POLICY:**

Behavior by medical staff members while on Hospital property that generates a complaint by another medical staff member, a member of the hospital clinical or administrative staff, or individuals in contact with the medical staff member at the hospital other than patients, will be responded to according to this policy. Behavior that indicates that the medical staff suffers from a physical, mental or emotional condition will be referred to the Medical Executive Committee or otherwise evaluated to promote assisting the medical staff member. Sexual harassment, harassment and other disruptive behavior is not acceptable to the medical staff and will be corrected, or if correction fails or the initial conduct warrants, disciplined.

“Disruptive behavior” means any conduct or behavior including, without limitation, sexual harassment or other forms of inappropriate behavior, which:

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i. Jeopardizes or is inconsistent with quality patient care or with the ability of others to provide quality patient care at the hospital;
ii. Is unethical; or
iii. Constitutes the physical or verbal abuse of patients or others involved with providing patient care at the hospital.

Disruptive behavior occurs in varying degrees, which are classified here into three levels of severity. Level I behavior is the most severe violation of this Policy. Any corrective action will be commensurate with the nature and severity of the disruptive behavior. Repeated instances of disruptive behavior will be considered cumulatively, and action shall be taken accordingly.

A. Classification of severity shall follow these guidelines:

**Level I:** Physical violence or other physical abuse which is directed at people. Sexual harassment or harassment involving physical contact.

**Level II:** Verbal abuse such as unwarranted yelling, swearing or cursing; threatening, humiliating, sexual or otherwise inappropriate comments directed at a person or persons; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing or pictures(s) directed at a person or person, or physical violence or abuse directed in anger at an inanimate object.

**Level III:** Verbal abuse which is directed at-large, but has been reasonably perceived by a witness to be disruptive behavior as defined above.

B. The medical staff shall promote continuing awareness of this Policy among the medical staff and the hospital community, including the following efforts:

i. Sponsoring or supporting educational programs on disruptive behavior to be offered to medical staff members and hospital employees;
ii. Disseminating the Policy to all current members upon the adoption of the Policy and to all new members of the medical staff upon joining the staff; and
iii. Requiring the Medical Staff Executive Committee to assist a member of the medical staff exhibiting disruptive behavior to obtain education, behavior modification, or other treatment to prevent further violations.

**PROCEDURE:**

Complaints about a member of the medical staff regarding alleged disruptive behavior must be in writing, signed and directed to the Medical Executive Committee. The Medical Executive Committee, or designee, must review the complaint immediately, and provide the complainant with a written acknowledgement of the complaint and this policy. The Medical Executive Committee or designee shall make an initial determination of authenticity and severity, and act accordingly. In all cases, the member involved shall be provided with a copy of this policy and a copy of the complaint. If no corrective action is taken, a confidential memorandum summarizing the disposition of the complaint shall be retained in the member’s credentials file for one year, and then expunged, if no related action is taken or pending.

At the discretion of the President of the Medical Staff or at the discretion of the Medical Executive Committee, the duties here assigned to the President of the Medical Staff can be delegated to a different officer of the Medical Staff, on a case-by-case basis or for the President’s term of office.

A. **Level I**

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The Medical Executive Committee shall interview the complainant and, if possible, any witnesses within 24 hours of receiving the complaint. The complainant may request that a second member of the Medical Executive Committee be present. The Medical Executive Committee shall interview the medical staff member within 24 hours. The Medical Executive Committee shall provide the member the opportunity to respond in writing.

The Medical Executive Committee shall do one or more of the following:

i. Determine that no action is warranted.
ii. Issue a warning.
iii. Require a written apology to the complainant.
iv. Initiate corrective action pursuant to the medical staff bylaws.

B. Level II

The Medical Executive Committee shall interview the complainant and, if possible, any witnesses within 5 working days of receiving the complaint. The Medical Executive Committee and another member of the medical executive committee shall interview the medical staff member within 5 working days. The Medical Executive Committee shall provide the member the opportunity to respond in writing. The Medical Executive Committee shall do one or more of the following:

i. Determine that no action is warranted
ii. Issue warning
iii. Require a written apology to the complainant.
iv. Initiate corrective action pursuant to the medical staff bylaws.

C. Level III

The Medical Executive Committee shall interview the complainant and, if possible, any witnesses within 10 days of receiving the complaint. The Medical Executive Committee shall provide the member the opportunity to respond in writing. The Medical Executive Committee shall do one or more of the following:

i. Determine that no action is warranted.
ii. Issue warning
iii. Require a written apology to the complainant
iv. Initiate corrective action pursuant to the medical staff bylaws.

DISRUPTIVE BEHAVIOR AGAINST A MEDICAL STAFF MEMBER

Disruptive behavior which is directed against a medical staff member by a hospital employee, board member, contractor, or another member of the hospital community shall be reported by the member to the hospital pursuant to hospital policy governing conduct.

OTHER BEHAVIOR

Behavior by a medical staff member towards a hospital employee, board member, contractor or other member of the hospital community, which does not fall within the definition of disruptive behavior above, but violates hospital policy governing conduct, shall be dealt with according to that hospital policy, so long as the hospital policy has been approved by the medical executive committee.

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ABUSE OF PROCESS

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by members against complainants will give rise to corrective action pursuant to the medical staff bylaws. Individuals who submit a complaint or complaints which are determined to be false shall be subject to corrective action under the medical staff bylaws or hospital employment policies, whichever applies to the individual.