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The following definitions shall apply to terms used in this Policy:

(a) "Accredited Residency" when used with respect to training obtained by a Physician means a postgraduate residency training program which has been either (i) approved by either (1) the Board of Directors of the American Osteopathy Association and as listed in the Yearbook and Directory of Osteopathic Physicians, Osteopathic Postdoctoral Training Programs Section, as published by the American Osteopathic Association for the year the applicant’s residency was completed or (2) the Accreditation Council on Graduate Medical Education of the American Medical Association (“ACGME”) and as listed as accredited in the Directory of Graduate Medical Education Programs published by the ACGME for the year the applicant’s residency was completed, or (ii) accepted by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists of the American Osteopathic Association as satisfying such Specialty Board’s minimum requirements to permit a physician to sit for its certifying examination, provided that such physician in fact has so satisfactorily passed the examination and other criteria for such Specialty Board to receive certification therefrom. For the purposes of determining whether a residency satisfies the foregoing, a Physician will be deemed to have satisfied these requirements if the last full year of his/her residency training is from such an approved or accredited program.

(b) “Advanced Practice Registered Nurse” means and refers to those registered nurses who have obtained additional, specialized education beyond the basic nursing education through the completion of an advanced degree in nursing from an accredited institution, who are licensed by the Montana Board of Nursing to practice professional nursing, who are certified by a nationally recognized professional organization as having a nursing specialty or otherwise meet the criteria for advanced practice nurses established by the Montana Board of Nursing, and who are certified by the Montana Board of Nursing as an Advanced Practice Registered Nurse. Advanced Practice Registered Nurses include certified nurse midwives, certified registered nurse anesthetists, nurse practitioners and clinical nurse specialists.

(c) “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 or Scopes of Practice by the Board of Directors. Allied Health Professionals may be employees of the Hospital if an
Advanced Practice Registered Nurse or Physician Assistant, independent healthcare providers, or employees of Members of the Medical Staff. Examples of Allied Health Professionals are Advanced Practice Registered Nurses, Physician Assistants, Psychologists, technologists, therapists, and registered nurses and Medical Assistants if employed by Members of the Medical Staff. Nurses and Allied Health Professionals 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.

(d) “Board of Directors” means the Board of Directors of the Hospital, which is the governing body of the Hospital and which has the overall responsibility for the conduct of the Hospital and shall include, where appropriate, a committee of the Board of Directors designated to act on behalf of the Board of Directors with respect to a particular function or duty.

(e) “Board Certified” or “Board Certification” means the certification by a Specialty Board which is recognized or certified by either the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists of the American Osteopathic Association that a Physician has satisfactorily passed the examination and other criteria of such Specialty Board for such certification.

(f) “Bylaws” means the Medical Staff Bylaws as approved by the Board of Directors, unless otherwise designated “Bylaws of the Hospital.”

(g) “CEO” means the person appointed by the Board of Directors to serve as the chief executive officer and administrator of the Hospital and who currently is also the President of the Hospital.

(h) “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 specific patient care or perform specific diagnostic, therapeutic, medical, dental or surgical procedures in the Hospital pursuant to this Policy.

(i) “Corporate Compliance Officer” means the person designated by the Hospital with responsibility for compliance of the Hospital, its employees, the Medical Staff and other healthcare providers and contractors with the Organizational Responsibility Program and with other Hospital policies and various laws affecting the Hospital. Such officer is currently the VP Clinical Support/ORO.

(j) “Credentials Committee” means the Credentials Committee of the Medical Staff.

(k) “Dentist” means both a doctor of dental surgery and doctor of dental medicine who has a current license issued by the Montana State Board of Dentistry to practice dentistry.

(l) “Department” means one of the divisions or departments into which the Medical Staff is divided according to professional specialty and to which all Members of
the Medical Staff are assigned for governance, call scheduling and peer review purposes.

(m) “Direct Supervision” means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure.

(n) “Director of Medical Staff Services” means the person designated by the Hospital who has the administrative responsibility for processing and coordinating with Medical Staff Departments, Sections and committees their review of applications for appointment or reappointment to the Medical Staff and requests for Clinical Privileges and applications for Clinical Privileges and Scopes of Practices of Allied Health Professionals.

(o) “Ethical Religious Directives” means the Ethical and Religious Directives for Catholic Health Facilities to which the Hospital and its employees and providers are subject, as referenced in Section 2.A.6.

(p) “General Supervision” means the physician does not have to be present on the premises and designated staff performs under his/her direction.

(q) “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

(r) “Hospital” means St. Vincent Healthcare and the hospital facilities and ancillary buildings located at 1233 North 30th Street, Billings, Montana constituting St. Vincent Healthcare.

(s) “Joint Commission” means The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, or its successor.

(t) “Medical Assistants” means and refers to those dependant health care professionals who (i) provide medical services as employees of and under the direct supervision of Physicians, Dentists or Podiatrists who are presently appointed to the Medical Staff, (ii) generally are not licensed or certified as healthcare providers and (iii) are individually authorized by the Board of Directors to assist such Medical Staff Members in the provision of healthcare as specifically delineated. Medical Assistants include scrub techs, certified O.R. techs, obstetrical techs, O.R. techs, dental techs and dental hygienists.

(u) “Medical Executive Committee” means the Executive Committee of the Medical Staff, unless specifically written “Executive Committee of the Board.”

(v) “Medical Staff” means the collective body of all Physicians, Dentists and Podiatrists who are appointed thereto by the Board of Directors and who may be granted Privileges to treat patients at the Hospital.
“Medical Staff Development Plan” means the business plan(s), if any, adopted by the Board of Directors, as amended from time to time, concerning the Hospital’s Physician and other healthcare provider personnel needs, facilities and resource allocation.

“Member” means any Physician, Dentist or Podiatrist who has a current Medical Staff appointment and who may have Clinical Privileges granted by the Board of Directors to practice at the Hospital.

“Organizational Responsibility Program” means the policy of the Hospital adopted by the Board of Directors confirming the philosophy and intent of the Hospital that all of its activities be conducted in a legal and ethical manner, including its dealings with independent contractors and healthcare providers, and establishing a program to detect possible violations of law and ethical standards/practices within the Hospital.

“Personal Supervision” means the physician must be present in the room during procedure.

“Physician” means and refers to both a doctor of medicine (“M.D.’s”) and doctor of osteopathy (“D.O.’s”) who has a current license issued by the Montana State Board of Medical Examiners to practice medicine and surgery.

“Physician Assistants” means and refers to those healthcare professionals who provide medical services as employees of and under the direct supervision of Members of the Medical Staff or as employees of the Hospital, who have satisfied the requirements for certification as a physician assistant under Montana law and who have received a certificate of registration as a physician assistant from the Montana Board of Medical Examiners or a designated agency thereof to practice as a physician assistant.

“Podiatric Clinical Residency” when used with respect to training obtained by a Podiatrist means a clinical residency in podiatric medicine or surgery of not less than one (1) year which is approved by the Council on Podiatric Medical Education of the American Podiatric Association and which was sponsored by and conducted in an institution such as a hospital or conducted by a college of podiatric medicine accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

“Podiatrist” means a doctor of podiatric medicine or surgery who has a current license issued by the Montana State Board of Podiatry to practice podiatry and has successfully completed a Podiatric Clinical Residency.

“Practitioner” means any appropriately licensed Physician, Dentist or Podiatrist inquiring about an application for Medical Staff appointment, or applying for or exercising Clinical Privileges at the Hospital.
Quality and Patient Safety Committee of the Board of Directors means the committee established by the Board of Directors to provide advice and consult to the Board of Directors concerning Medical Staff appointment and credentialing of Practitioners and Allied Health Professionals and the granting of Clinical Privileges.

“Scope of Practice” means the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency. Each state has laws, licensing bodies, and regulations that describe requirements for education and training.

“Special Notice” means written notice which is given or sent by certified or registered United States Mail, postage prepaid, return receipt requested, and when directed to a Practitioner or Allied Health Professional shall mean addressed to the Practitioner or Allied Health Professional at his or her last office home address on file with the Director of Medical Staff Services. When reference to receipt of such notice is made in this Policy it shall mean the earlier of actual receipt by the Practitioner or Allied Health Professional or his or her agent or the first date delivery was attempted by the United States Postal Service as conclusively evidenced by the date shown on the return receipt or envelope in which the notice was mailed.

“Specialty Board” means that certifying agency or board relating to a medical specialty (or subspecialty) as recognized or authorized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialists of the American Osteopathic Association or by the Royal College of Physicians and Surgeons of Canada to issue certificates of special recognition of physicians’ training and expertise in a specialty or subspecialty.

Words used in this Policy shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this policy.

ARTICLE 2

APPOINTMENT TO THE MEDICAL STAFF

2.A. QUALIFICATIONS FOR APPOINTMENT

2.A.1. General

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 as set forth in this Policy, and in such credentialing criteria or policies as are adopted from time to time by the Board of Directors, and in such standards as are set forth in the Bylaws, Medical Staff Rules and Regulations, if any, and rules and regulations of the Departments of the
Medical Staff as are approved by the Board of Directors, in effect at the time of appointment or granting of Privileges and as amended from time to time. Appointment shall confer on the appointee only such Privileges as have been granted by the Board of Directors in accordance with this Policy. This Policy, the Bylaws, rules and regulations of the Medical Staff, rules and regulations of Departments 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 exempted by specific provisions of this Policy, including Practitioners engaged either part or full-time by the Hospital in administrative capacities if such activities include clinical responsibilities, must first have been appointed to the Medical Staff and maintain their appointment in good standing. Any inconsistency between the Bylaws and this Policy concerning the requirements for appointment to the Medical Staff shall be controlled by this Policy.

2.A.2. Specific Qualifications

(a) Appointment to the Medical Staff Other Than The Honorary Staff:

Only Physicians, Dentists–and Podiatrists seeking appointment to the Medical Staff, other than the Honorary Staff category, who satisfy the following conditions shall be qualified for appointment to the Medical Staff:

(1) have a current unrestricted license to practice in the state in which the physician will provide care;

(2) possess current, valid professional liability insurance coverage in such form, with such insurers and in such amounts as are satisfactory to the Board of Directors;

If a physician is applying for a new appointment, he or she must have:

(3) Completed an accredited residency in the specialty or subspecialty in which the applicant principally seeks clinical privileges and also,

   (i) Be board certified in the applicant’s primary specialty; or

   (ii) If not a member of the Medical Staff prior to February 1, 2007 or did not continuously remain a Member of the Medical Staff the following requirements are in force:

       1. Have satisfied the requirements of the appropriate Specialty Board and be board certified within five (5) years of completion of his/her Accredited Residency or Fellowship;

       2. If the applicant is not board qualified, or more than five (5) years have elapsed from the end of his/her residency or
fellowship, the applicant will not be eligible for appointment, or

(3) IF APPLYING FOR REAPPOINTMENT to the Medical Staff:

Be Board Certified in Member’s primary specialty except for those Members of the Medical Staff first appointed prior to February 1, 2007 and who have remained Members since initial appointment who shall be exempt from such Board Certification requirement; or

(i) If not a member of the Medical Staff prior to February 1, 2007 or did not continuously remain a Member of the Medical Staff he or she must:

1. If more than five (5) years has elapsed since completion of residency or fellowship training program, or more than three (3) years from the time of initial appointment; the applicant will not be eligible for reappointment.

2. Maintain continuous Board certification in his/her primary area of specialty. If Board Certification expires during the appointment period, appointment will automatically cease at that time unless;

   a. Member has made a good faith attempt to recertify prior to the expiration of their board; and

   b. Member submits a plan to become recertified at the first opportunity following the expiration of the board and the Medical Executive Committee and the Board of Directors accepts the plan. This extension may be granted for no more than the time allotted to complete the recertification at the earliest opportunity offered by the board.

(4) if the applicant is a Podiatrist, have either (i) successfully completed a Podiatric Clinical Residency in surgery or medicine, or (ii) been designated a Diplomate of the American Board of Podiatric Medicine provided the applicant’s Privileges are limited to non-surgical procedures;

(5) have not been convicted of, pleaded guilty to a charge of, or entered a plea of no contest to a charge of, a felony or a pattern of misdemeanor offenses which reasonably relates to the ability of the Practitioner to exercise the Clinical Privileges sought to be granted, whether or not sentence was imposed;
have not been excluded or debarred from any government funded program of healthcare, such as, but not limited to, the Medicare or Medicaid programs or TRICARE (formerly CHAMPUS);

comply with the requirements set forth in the Bylaws for appointment to the staff category to which appointment is sought;

can document their:

(i) relevant background, current experience, training, continuing medical education, medical/clinical knowledge, demonstrated current competence, patient care, practice-based learning and improvement, and systems-based practice,

(ii) professionalism and adherence to the ethics of their profession,

(iii) good character and reputation, and that such reputation and nature of their practice is not contrary to the mission or tenets of the Hospital, and would not subject the Hospital to embarrassment, conflict, disruption or otherwise not be in the best interest of the Hospital;

(iv) ability to perform, with or without an accommodation, the essential functions required for the Clinical Privileges requested without posing a direct threat to the health or safety of the Practitioner, patients or others;

(v) communicative skills, including their ability to speak and write legibly the English language, to the extent necessary to communicate effectively and be able to provide medical services as may be needed by any patient at the Hospital; and

(vi) the ability to work harmoniously with others,

with sufficient adequacy to assure the Board of Directors that any patient treated or examined by the applicant will receive high-quality medical care and that the orderly administration of the Hospital will not be adversely affected;

conform to the Medical Staff Development Plan, if any, the Bylaws, the Medical Staff Rules and Regulations, and this Policy; and

initially agree to conform, and if appointed conform, to the Ethical Religious Directives set forth in Section 2.A.6.
(b) Honorary Staff Appointment

Only Physicians, Dentists or Podiatrists seeking appointment to the Honorary Staff category of the Medical Staff who satisfy the following conditions shall be qualified for appointment to the Honorary Staff:

(1) have retired from active practice at the Hospital, or;

(2) are Physicians, Dentists or Podiatrists of outstanding reputation, not necessarily residing in the community.

2.A.3. No Automatic Entitlement to Appointment or Reappointment

No Practitioner shall be entitled to appointment to the Medical Staff or a specific category of the Medical Staff, no Member shall be entitled to reappointment to the Medical Staff, and no Practitioner shall be entitled to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that such Practitioner:

(a) is licensed to practice a profession in the State of Montana or any other state;

(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, medical staff appointment or Privileges at any hospital, including this Hospital;

(d) is currently a Member of the Medical Staff in a staff category which has or provides no Clinical Privileges at this Hospital;

(e) resides in the geographic service area of the Hospital as defined by the Board of Directors; or

(f) satisfies the threshold requirements or qualifications for appointment set forth in Section 2.A.2 or for reappointment as set forth herein.

2.A.4. Board of Directors has Ultimate Responsibility and Authority for Appointment

Pursuant to Montana law (including applicable regulations) and Joint Commission standards, the Board of Directors has the ultimate responsibility and authority with respect to making appointments and reappointments to the Medical Staff and granting of Clinical Privileges and the Board of Directors may also consider in addition to whether the applicant satisfies the basic qualifications for appointment, the applicant’s employment by or affiliation with competing organizations, the effect appointment of the applicant would have on Hospital operations, administration, or financial position, including the cost of Hospital’s provision of specific services or procedures, effect on Hospital’s reputation, effect on Hospital’s competitive position, or any other factor in addition to the applicant’s competence and qualifications, which the Board of Directors determines in its discretion may adversely affect the best interests of patient care or the operations of Hospital.
2.A.5. Non-Discrimination Policy

No qualified Practitioner shall be denied appointment, reappointment or Clinical Privileges on the basis of sex, race, disability, creed, religion, color, national origin, age, veteran or military status or other legally protected status. Reasonable accommodations will be made for the known disabilities of qualified Practitioners. Practitioners are expected to cooperate fully in the identification and selection of reasonable accommodations, focusing on the abilities of the Practitioner and the health and safety of patients.

2.A.6. Ethical Religious Directives

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 Health Facilities (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 a written pledge signed by such applicant agreeing to abide by and conform with such Ethical Religious Directives.

2.B. PROCEDURE FOR INITIAL APPOINTMENT

2.B.1. Pre-Application Process

(a) An application for appointment to the Medical Staff shall only be sent upon written, verbal or email request to those Practitioners who, according to the Medical Staff Development Plan, the Bylaws and this Policy, are eligible for appointment to the Medical Staff; who meet established threshold criteria; and who indicate an intention to utilize the Hospital as required by the Medical Staff category to which they desire appointment.

(b) All Practitioners seeking appointment to the Medical Staff, other than to the Honorary Staff, and all Members of the Medical Staff seeking advancement in Medical Staff category, if otherwise qualified to do so pursuant to this Policy, shall complete and submit an application on forms developed and recommended by the Medical Executive Committee and approved by the Board of Directors.

(c) A Practitioner requesting an application for appointment shall initially be sent a letter that outlines the threshold criteria for appointment and applicable clinical Privileges, and explains the review process and shall include a pre-application questionnaire provided by the Director of Medical Staff Services, which form requests verification that the threshold criteria for appointment can be met by the Practitioner. A completed pre-application questionnaire with copies of all required documents must be returned to the Director of Medical Staff Services as
the designee of the CEO within sixty (60) days after receipt of same if the Practitioner desires further consideration.

(d) The Director of Medical Staff Services shall review the questionnaire to determine if the applicant meets the Hospital’s specific requirements for appointment. In cases of doubt as to the applicant’s ability to satisfy such threshold criteria, the Director of Medical Staff Services shall consult with the President of the Medical Staff or CEO. Those Practitioners who meet the threshold criteria set forth in Section 2.A.2(a)(1) through (6) shall be given an application for appointment by the Director of Medical Staff Services as the designee of the CEO. Practitioners who fail to meet the threshold criteria set forth in Section 2.A.2(a)(1) through (6) shall not be given an application and shall be so notified. Further, no application shall be accepted for processing from such Practitioners.

(e) No application shall be furnished to any Practitioner:

1. if requesting Clinical Privileges or membership in a department or clinical area which is closed pursuant to the Medical Staff Development Plan,

2. where the Hospital has entered into an exclusive contract for the provision of professional services within the clinical area in which the prospective applicant requests to practice (and the applicant will not be associated with the group having the exclusive contract),

3. where the Hospital has either elected not to provide the service in which the prospective applicant seeks Privileges or does not have the ability to provide adequate facilities or services for the prospective applicant or the patients to be treated by the prospective applicant,

4. the prospective applicant has interests or activities that are inconsistent with the needs, mission, operations and plans of the Hospital and the communities it serves, including any Medical Staff Development Plan, or has indicated an unwillingness to abide by the Ethical Religious Directives as referenced in Section 2.A.6, following review by the Credentials Committee.

5. the prospective applicant has been excluded from participation in any governmental sponsored healthcare program, including, but not limited to the Medicare or Medicaid programs,

6. the prospective applicant does not meet the requirements relating to licensure and registration or professional liability insurance.

7. the prospective applicant has been convicted of a felony or convicted of a misdemeanor related to the prospective applicant’s fitness to practice medicine,
(8) the prospective applicant has provided materially false or misleading information on any pre-application questionnaire or in connection with any pre-application review process, or

(9) the prospective applicant has failed to provide requested clarification as to his/her practice or information regarding the nature of his/her practice or qualification for appointment.

(f) No application shall be furnished to any prospective applicant who has received a final adverse decision concerning appointment, re-appointment, reinstatement or Clinical Privileges at the Hospital by reason of (1) a determination that such applicant failed to conform to relevant standards of professional competence, conduct or ethical conduct, (2) conviction of a felony or (3) revocation or suspension of the applicant’s license, certificate or other authority to practice medicine, dentistry or podiatry within the State of Montana by the applicant’s applicable licensing board or authority, or who has resigned or failed to apply for reappointment while under investigation in order to avoid investigation, or following an adverse recommendation by the Credentials Committee or Medical Executive Committee relating to the applicant’s professional competency, conduct or ethical conduct until after three (3) years has expired from such event unless the Board of Directors expressly provides otherwise. Except as provided in the preceding sentence, no application shall be furnished to any prospective applicant whose appointment was terminated or whose application was denied for any reason not included in (1), (2) or (3) above until after one (1) year has expired from such termination or denial, except as provided in Section 2.F.8. With any application, the applicant shall submit, in addition to all of the other information required, specific information showing that the condition or basis for the earlier adverse decision, recommendation or resignation no longer exists.

(g) If the prospective applicant is not provided an application, the prospective applicant shall be advised of the information relied on as grounds for not providing an application and the prospective applicant shall have a reasonable opportunity to submit information or evidence that the information relied on is not accurate.

(h) No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide the individual an application form for initial appointment.

2.B.2. Submission of Application

(a) To Whom Submitted:

The application for appointment shall be submitted by the applicant to the Director of Medical Staff Services as the designee of the CEO. The application must be accompanied by payment of the processing fee, if any, as it may be set from time to time. After reviewing the application to determine that all questions
have been answered, and that the applicant is eligible for appointment to the Medical Staff in the category sought after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Director of Medical Staff Services as the CEO’s designee shall transmit the completed application and all supporting materials to the appropriate Department Chairperson. In the event that an applicant who is requesting Privileges or membership in a department or clinical area where the Hospital has entered into an exclusive contract for the provision of medical services in such clinical area, or which is closed pursuant to the Medical Staff Development Plan, or otherwise does not satisfy the threshold criteria for appointment or the Clinical Privileges requested, is inadvertently provided an application and submits an application, the CEO or his/her designee shall notify the applicant that the application cannot be processed and the reasons for such. This action shall not entitle the applicant to any procedural rights, including a hearing, as set forth in this Policy.

(b) Contents of Application:

The application shall contain a request for specific Clinical Privileges desired by the applicant, if applicable, and shall, in any event, require detailed information concerning the applicant’s professional qualifications including, but not limited to:

1. the names and complete addresses of at least three (3) peers (i.e. Physicians, Dentists or Podiatrists, as appropriate for the applicant), who have had recent extensive direct experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant’s present professional competence and character and ability to perform the transactions of the Privileges being requested. Such references may not be associated with or about to be associated with the applicant in professional practice, personally related to the applicant, or be serving as Chairperson of the Department to which the Practitioner would be appointed, unless otherwise approved by the applicable Department Chairperson for applicants for appointment when the requirement of independent peers is not practical. At least one (1) reference shall be from the same specialty area as the applicant and, where feasible, one such reference shall be a Member of the Active Staff at the Hospital;

2. the names, complete addresses and contact information of the Department Chairpersons of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as Chairpersons at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great, or if a number of years have passed since the applicant worked at a particular hospital, the Credentials Committee, the Medical Executive Committee and the Board of Directors may take such factors into consideration in reviewing and verifying information from such sources;
information as to whether the applicant’s medical staff appointment or Clinical Privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, surrendered, revoked, suspended, subjected to probationary conditions, reduced or not renewed at any other hospital or health care facility;

a complete chronological listing of the applicant’s professional and educational appointments, employment or medically related positions after graduation from medical, osteopathic, podiatric or dental school or university as to psychologists;

information as to whether the applicant has ever either voluntarily or involuntarily withdrawn his/her application for appointment, reappointment, or Clinical Privileges, or resigned from the medical staff of any hospital before final decision by a hospital’s or health care facility’s governing board concerning such application;

information as to whether the applicant’s membership in any local, state, or national professional society is or has ever been suspended, modified, terminated, restricted, or has ever been, or is currently being, challenged;

information as to whether the applicant’s license to practice any profession in any state, or Drug Enforcement Administration registration, is or has ever been either voluntarily or involuntarily surrendered, suspended, modified, terminated, restricted, or has ever been, or is currently being, challenged. The submitted application shall include a list or copy of all the applicant’s current licenses to practice, as well as copies of (i) Federal Drug Enforcement Administration registration with a Montana practice address if the practitioner will physically be practicing within the state, and (ii) medical, osteopathic and dental school and (iii) certificates from all post graduate training programs completed;

information as to whether the applicant has currently in force professional liability insurance coverage, the name and address of such insurance company and the amount and classification of such coverage, and whether said insurance coverage covers the Clinical Privileges the applicant seeks to exercise at the Hospital. The submitted application shall include a certificate evidencing the required insurance with the hospital listed as the certificate holder along with the name of the practitioner as a covered entity;

the identity, including address and contact information, of applicant’s professional liability insurer for each of the ten (10) immediately preceding years if different than applicant’s current insurer;

detailed information concerning the applicant’s professional liability litigation and claim experience, which shall specifically include
information concerning any prior or pending litigation, final judgments, arbitration awards or settlements;

(11) information concerning any professional misconduct proceedings involving the applicant in the State of Montana or any other state, whether closed or still pending, including the following information: (i) the substance of the allegations; (ii) the findings; (iii) the ultimate disposition; and (iv) any additional information concerning such proceedings or actions as the Credentials Committee, Medical Executive Committee or Board of Directors may deem appropriate;

(12) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid or any other government sponsored healthcare program or any private or public medical insurance program;

(13) except for applicants to the Consulting Staff, Affiliate Staff or Telemedicine Staff categories, the identity of Member of the Medical Staff having equivalent Clinical Privileges upon whom the applicant can rely (and who has agreed) to provide coverage or back-up for applicant’s patients if applicant is otherwise unavailable to care for applicant’s patients unless no such alternate is available on the Medical Staff (in which event the Board may, but shall be under no obligation to, waive such requirement);

(14) a consent to the release of information, utilizing the approved form without modification, from the applicant’s present and past professional liability insurance carriers, all hospitals or health care facilities at which the applicant has or has had Privileges and all educational facilities, hospitals or other institutions or medical providers at which or with whom applicant received any medical training or education;

(15) a statement that the applicant is able to perform, with or without accommodation, all of the essential functions of the Clinical Privileges which the applicant is requesting without posing a direct threat to the health or safety of the applicant, patients or others;

(16) information as to whether the applicant has ever been convicted of, pleaded guilty to a charge of, or entered a plea of no contest to a charge of commission of a crime (excluding minor traffic violations but including driving under the influence), with details about any such instance, whether or not sentence was imposed or suspended and whether or not probation was granted (convictions will not necessarily result in ineligibility for appointment);

(17) an agreement that if Medical Staff appointment is recommended by the Medical Executive Committee the applicant will provide additional
information if requested concerning his/her health status, both physical and mental;

(18) acknowledgement of receipt of the Hospital’s Organizational Responsibility Program and agreement not to violate such Program;

(19) acknowledgment attesting that applicant has read the Hospital’s Sexual Harassment and the Medical Staff Policy;

(20) acknowledgment attesting to the applicant’s pledge to abide by the Ethical Religious Directives as referenced in Section 2.A.6;

(21) acknowledgment that the applicant will meet with the applicable Department Chairperson or appear before the Credentials Committee, Medical Executive Committee, Provider Review Committee or Board of Directors or any of their designee to answer any questions about the applicant’s application or practice;

(22) evidence of the applicant’s successful completion of the Hospital’s learning module and test regarding HIPAA and its requirements for the protection of the confidentiality of patient healthcare information;

(23) a current government issued photograph of applicant (e.g., passport, driver’s license, etc.) to be used for verification of identity;

(24) the applicant’s signature and date; and

(25) such other information as the Board of Directors may require (e.g., procedure logs, vaccinations, safety education, background release, etc.).

(c) When Application Complete

An application shall not be deemed to be complete until all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been primary source verified as necessary, and until it has been reviewed by the appropriate Department Chairperson, Credentials Committee and Medical Executive Committee and all have determined that no further documentation or information is required to permit full consideration of the application. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. It is the responsibility of the applicant to provide a complete application, including adequate responses from references and primary sources. An application which is incomplete in any respect, including the failure to furnish any supporting documentation, will not be processed until completed and in the event additional information is requested as provided above, such application shall not be further processed until such additional information is provided as requested. Any application that continues to be incomplete sixty (60) days after the applicant has been notified of the failure to provide any information initially requested on the
application form or of any additional information thereafter requested shall be deemed to be incomplete and withdrawn. Notwithstanding anything contained in the foregoing to the contrary, an application may be processed if the only missing documentation is the issuance of the applicant’s Montana license or a Federal Drug Enforcement Agency registration provided the applicant was not a resident of the State of Montana within six months prior to submission of the application, applicant has applied for such license and applicant has provided a copy of applicant’s application for such a license to the Director of Medical Staff Services if missing the license or evidence of application for the Montana DEA registration. In addition, in the case of an applicant who is completing a residency or fellowship program, such applicant’s application may be processed pending receipt of professional liability insurance, verification of program completion or Montana DEA registration. However, under no circumstances shall any application be processed beyond the Chairperson of the applicable Department if the application is incomplete in any respect unless specifically approved by CEO.

In the event that the credentialing information obtained from outside sources varies substantially from that provided by the applicant as determined by the Director of Medical Staff Services, after consultation with the Chairperson of the Credentials Committee, the applicant will be notified of the discrepancy by the Director of Medical Staff Services by Special Notice after receipt of the contrary information and shall be given the opportunity to refute such discrepancy. The applicant may view that portion of his/her own file that he/she has contributed and may review information obtained by the Hospital in evaluating the application, including information obtained from any outside source such as malpractice insurance carriers and state licensing boards, but excluding responses (evaluations) from references and peer recommendations which reflects contrary information. The applicant shall submit written documentation to the Director of Medical Staff Services explaining or correcting the discrepancy within fifteen (15) days from the date of notification of the discrepancy. Failure to respond within said fifteen (15) days shall be deemed acceptance as accurate such contrary information received by the Director of Medical Staff Services. The Director of Medical Staff Services will acknowledge in writing receipt of such follow-up documentation from the applicant. Director of Medical Staff Services will verify the corrected information with the primary source.

(d) Basic Responsibilities for Applicants and Members

Submission of an application for appointment or reappointment to and acceptance of appointment or reappointment to the Medical Staff, if granted, shall be deemed an agreement by the applicant that he/she agrees to and accepts the following responsibilities and obligations:

(1) provide continuous care and supervision to all patients within the Hospital for whom the Practitioner has responsibility;
be subject to, abide by, and conform with all applicable bylaws, policies and rules and regulations of the Medical Staff, and Department and Section to which appointed where applicable, and of the Hospital, currently in effect and as amended from time to time, including, but not limited to, the following policies: Disruptive Behavior and the Medical Staff Policy and Provider Health policy concerning Practitioners with disruptive behavior, physical or mental impairment or with chemical impairment;

if applicable to the Medical Staff category to which appointed, accept committee assignments and such other reasonable duties and responsibilities, including professional review activities, quality assessment activities, and emergency calls, as shall be assigned;

provide to the Director of Medical Staff Services and the CEO, with or without request, new or updated information, as it occurs, that is pertinent to any question on the application form, whether before granting of appointment or thereafter, including but not limited to providing updated or additional information concerning (i) the filing of or significant change in any professional liability action against the Practitioner; (ii) the filing of any complaint with, or the commencement of any disciplinary action, investigation or proceeding by the applicable state licensing board of any state in which the Practitioner is licensed concerning the Practitioner’s professional conduct or competency, license or registration; (iii) the filing of any complaint with, or the commencement of an investigation, proceeding or disciplinary action by the federal or state government or any agency or department thereof concerning the Practitioner’s professional conduct, billing practices, competence, license or registration, (iv) the filing of any complaint with, or the commencement of any investigation or proceeding (including any suspension other than for failure to complete medical records) which may or does affect the applicant’s Clinical Privileges or appointment at any other hospital or professional association or society; (v) receipt of notice of any change in status of the Practitioner’s professional liability insurance or coverage, including cancellation, non-renewal, reduction or restriction in coverage or imposition of any conditions on the Practitioner’s practice or coverage with respect thereto; (vi) conviction of, pleading guilty to a charge of, or entering a no contest plea to a charge of, any criminal offense (including driving under the influence but excluding minor traffic violations) whether or not sentence was imposed, suspended or probation granted, which criminal offense reasonably could relate to the ability of the Practitioner to exercise the Clinical Privileges sought; (vii) notification of the loss of his/her DEA number or exclusion or debarment from the Medicaid, Medicare or other government sponsored healthcare benefit program, is under investigation by Medicaid or Medicare, or has been subjected to any fine, penalty or sanction by Medicare or Medicaid; (viii) the voluntarily relinquishment, agreement not to exercise, or involuntary loss of any licensure,
certification, registration, medical staff membership or Clinical Privileges at any healthcare facility; (ix) entering into an agreement with any impaired physicians committee or similar entity as a result of any substance abuse or other disease or disorder; or (x) development of any mental or physical illness or having sustained any injury which could have an effect on the ability of the Practitioner to exercise the individual’s Clinical Privileges;

(5) immediately notify the Director of Medical Staff Services and the CEO by telephone and in writing of any change in his or her eligibility for payment for services by third-party payors because of quality of care issues or billing practices or for participation in Medicare or Medicaid on a reimbursable basis (other than applicant’s voluntary election not to participate in such programs), including the transmitting of a sanction recommendation to the Office of the Inspector General (OIG) of the United States Department of Health and Human Services or the imposition of an exclusion sanction by the Secretary of Health and Human Services or any monetary penalty imposed in lieu of exclusion. The term “exclusion sanction,” as used in this Policy, shall refer only to the formal imposition of an exclusion sanction by the Secretary of Health and Human Services upon the recommendation of a review organization or the OIG or similar state agency, whereby the Practitioner is excluded totally from eligibility to participate in Medicare or Medicaid on a reimbursable basis. An exclusion sanction must be evidenced by a written notice of sanction from the OIG;

(6) appear, if requested, for personal interviews in regard to the application;

(7) agree to provide any information or documentation, including appropriate medical records, which may be requested to answer any questions or resolve any issues concerning the Practitioner’s clinical competence or conduct, or to provide information concerning any matters or actions set forth in item (4) above;

(8) agree that any significant misrepresentation, misstatement or omission determined by the Director of Medical Staff Services, after consultation with the Chairperson of the Credentials Committee, to exist after having been provided an opportunity to refute any discrepancies, if applicable, in, or omission from, the application whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and Clinical Privileges by the Board with recommendation from the Medical Executive Committee. In the event of such misrepresentation, Hospital may decline to process such application as an incomplete application and such application shall be deemed withdrawn. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or
omission, such discovery shall be grounds for and may result in summary suspension or dismissal from the Medical Staff;

(9) agree that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken at the Hospital;

(10) refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(11) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(12) refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(13) seek consultation whenever the Practitioner deems it reasonably necessary or appropriate under applicable standards of care;

(14) abide by generally recognized ethical principles applicable to the applicant’s profession, including, but not limited to, the American Medical Association and American Osteopathic Association;

(15) if required by the Medical Staff category sought or to which appointed, participate in the monitoring and evaluation activities of clinical departments;

(16) complete in a timely, accurate and legible manner the medical and other required records for all patients treated or examined by them, as required by the Bylaws and the Medical Staff Rules and Regulations;

(17) work cooperatively with Medical Staff Members, Allied Health Professionals, nurses, Hospital administration and other Hospital personnel so as not to adversely affect patient care or the orderly administration of the Hospital;

(18) promptly pay when due any applicable Medical Staff dues and assessments;

(19) if required by the Medical Staff category sought or to which appointed, participate in continuing education programs (both for his or her own benefit and the benefit of other professionals and Hospital personnel) relating to the applicant’s Clinical Privileges in accordance with Bylaws;

(20) provide annually certification of insurance of professional liability insurance with provider name listed as covered entity satisfying the requirements described in this Policy, current license to practice medicine,
dentistry or podiatry, as applicable, as required by this Policy and any other license or registration which is a condition to Medical Staff appointment to the category to which he/she is appointed;

(21) authorize the release of all information necessary for an evaluation of the Practitioner’s qualifications for initial or continued appointment, reappointment, and/or Clinical Privileges;

(22) conduct his/her activities at the Hospital in a manner consistent with and not in violation of the Hospital’s Organizational Responsibility Program;

(23) agree to submit accurate responses to Hospital’s health status questionnaire to the Quality and Patient Safety Committee of the Board if conditional appointment is recommended;

(24) maintain the confidentiality of Hospital’s strategic plans, budgets, financial information or other proprietary or confidential information which the applicant or Member may be provided or otherwise acquire by virtue of service on Medical Staff or Hospital committees or participation in Medical Staff functions, activities or otherwise;

(25) if seeking or granted Clinical Privileges, except for appointees to the Telemedicine Consulting or Affiliate Staff Categories, unless waived by the Board of Directors, continuously maintain (and keep the Director of Medical Staff Services advised of) a designated alternate having equivalent Privileges at Hospital to care for applicant’s or Member’s patients when the applicant or Member is unavailable or otherwise unable to care for his/her patients;

(26) agree not to solicit for employment by the Member or others on the Member’s behalf employees of Hospital during such employees’ working hours at Hospital when solicitation is potentially disruptive to patient care or Hospital’s operations (but such agreement shall not affect the ability of the Member to discuss employment opportunities outside of the employee’s working hours, recognizing the rights of employees to consider available employment opportunities);

(27) agree that the failure of a Practitioner to provide the notification as required by (4) above shall be grounds for suspension or other action related to the Practitioner’s Medical Staff appointment and/or Privileges,

(28) acknowledge that the failure to provide complete and accurate information in connection with any investigation concerning the Practitioner’s Medical Staff appointment or Clinical Privileges shall be grounds for immediate termination of Medical Staff appointment and Clinical Privileges,

(29) if seeking or granted Clinical Privileges, agree to provide upon request by the Department Chairperson, Credentials Committee or Medical Executive
Committee access to and copies of the Practitioner’s office charts and records relating to the treatment of patients who have been treated by the Practitioner in the Hospital or any related facility if deemed necessary for the review of the Practitioner’s professional activities and current clinical competence because of the lack of contact with the Hospital,

(30) cooperate with Medical Staff committees and investigating panels or subcommittees in any review or investigation of the Member’s patient care, competence, conduct or ability to practice without posing a danger to other Members, other providers or patients;

(31) agree to abide by the Ethical Religious Directives referenced in Section 2.A.6;

(32) actively participate in the Hospital peer review programs, including provisional monitoring and report conduct of Medical Staff Members, Allied Health Professionals and Hospital personnel of which he/she reasonably believes to be harmful to patient care or Hospital operation, and serve as a peer reviewer and testify on all matters within his/her knowledge before such peer review committees;

(33) participate and provide a leadership role in the measuring, assessing and improving the process and performance of clinical care including, but not limited to: education of patients and families and coordination of care with other Practitioners, Allied Health Professionals and Hospital personnel relevant to the care of an individual patient;

(34) assist in identifying community health needs, in setting appropriate institutional goals, and in implementing programs to meet those needs and goals;

(35) comply with relevant standards established by applicable provisions of federal, Montana, and local laws and regulations;

(36) exercise the authority granted by this Policy or the Bylaws as necessary to adequately fulfill the responsibilities assumed by the applicant pursuant to this Policy or the Bylaws;

(37) treat others with respect, courtesy and dignity and conduct themselves in a professional and cooperative manner as outlines in the Medical Staff code of conduct;

(38) agree not to sue the Hospital, its current or former employees, current or former Medical Staff members, or anyone acting by or for the Hospital and the Medical Staff for any matter relating to the application for appointment or reappointment, or Clinical Privileges, the collection of information regarding the applicant, the evaluation of the applicant’s
qualifications, processing of his/her application or any matter related to appointment, reappointment or Clinical Privileges; and

(39) extend absolute immunity to the Hospital, its current or former employees, current and former Medical Staff members and all individuals acting by or for the Hospital and/or the Medical Staff for all matters relating to appointment, reappointment and Clinical Privileges or the applicant’s qualifications for the same.

(e) Burden of Providing Information

(1) The applicant shall have the burden of producing information deemed adequate by the Medical Staff and the Board of Directors for a proper evaluation of his/her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications, including specifically information from other hospitals, and information concerning malpractice actions and disciplinary or competency investigations or actions, as the Medical Staff or any committee thereof or committee of any applicable Department may request in order to provide appropriate quality assessment and evaluation of the applicant’s qualification for appointment and the Clinical Privileges requested.

(2) The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

(3) Until the applicant has provided all information requested by the Board of Directors, the application for appointment will be deemed incomplete and will not be processed, except for such limited review or processing as may specifically be provided in Section 2.B.2.(c) of this Policy.

(4) Should information provided in the initial application form change during the course of the appointment term, the applicant has the burden to provide as soon as reasonably possible to the Director of Medical Staff Services and Credentials Committee sufficient information about such change for the Credentials Committee to review and assess such change.

(f) Providing Verification of Identity

At any time following submission of the completed application for appointment to the Medical Staff and prior to the Board of Director’s final action on such application, each applicant for appointment to the Medical Staff shall provide verification of his/her identity by personally appearing before a representative of the Director of Medical Staff Services and presenting to such representative a government-issued photo identification so that the above representative may personally verify the identity of the applicant. Such verification shall be processed in accordance with the Practitioner Identification Policy established by the Director of Medical Staff Services, as amended from time to time. No
application for appointment shall be finally approved until the applicant has so personally appeared and provided such required verifying identification. The Hospital shall have the right to waive the foregoing requirement as to applicants employed by or under contract with a physician group providing remote telemedicine services to the Hospital if such employing group is then accredited by The Joint Commission to perform credentialing of its physicians upon which hospitals may rely and delegate certain credentialing responsibilities, provided that such physician group provides evidence satisfactory to the Director of Medical Staff Services of its verification of the identity of their employee or contractor who is applying for appointment.

2.B.3. Department Chairperson Procedure/Findings

(a) Following receipt of a completed application and verification by the Director of Medical Staff Services of the required information, the Director of Medical Staff Services shall transmit the application and accompanying information to the Chairperson of the Department in which the applicant seeks Clinical Privileges. The Department Chairperson or his/her/their designee shall provide the Credentials Committee with a written report on a form prescribed by the Credentials Committee concerning the applicant’s qualifications for appointment and specific written findings supporting the proposed delineation of the applicant’s Clinical Privileges. The Chairperson or his/her/their designee shall use reasonable efforts to complete such report within thirty (30) days from the Chairperson’s receipt of the applicant’s application. Such report shall include information as to the Department affiliation, and any conditions relating to appointment and shall state whether the applicant is qualified for the Clinical Privileges requested. The reasons for the findings of the Chairperson shall be stated in the report and supported by reference to the completed application and any other documentation considered. In the absence of the Department Chairperson or where there may be a conflict of interest between the applicant and the Chairperson, the application shall be referred to the Vice-Chairperson or other designee of the Department Chairperson as provided in the Bylaws. In the event any Chairperson, Vice-Chairperson or other designee to whom the application has been referred is not able to complete such report within said thirty (30) days, he or she shall so notify the Chairperson of the Credentials Committee. This report shall be appended to the Credentials Committee’s report. As part of the process of making this report, the Department Chairperson, Vice-Chairperson or his/her/their designee shall have the right to meet with the applicant to discuss any aspect of the application, the applicant’s qualifications and/or requested Clinical Privileges.

(b) The Department Chairperson, Vice-Chairperson or his/her designee, as applicable, shall evaluate the applicant’s education, training, and experience. Such evaluation shall include inquiries directed to the applicant’s past or current department chairperson, residency training director, as available or applicable, and others who may have knowledge about the applicant’s education, training, experience, and ability to work with others.
(c) In the event that any Department Chairperson, Vice Chairperson or his/her/their designee, evaluating the application finds that a change in Clinical Privileges from those requested is appropriate, he/she (or his/her designee) shall discuss such findings with the applicant before his/her report and the application are forwarded to the Credentials Committee Chairperson.

(d) When the evaluation is complete, the report of the Department Chairperson, Vice-Chairperson or his/her/their designee shall be delivered to the Chairperson of the Credentials Committee.

(e) The Department Chairperson, Vice-Chairperson or his/her/their designee shall be available to the Credentials Committee to answer any questions that may be raised with respect to the Chairperson’s, Vice-Chairperson’s or designee’s report and findings.

2.B.4. Credentials Committee Procedure/Findings

(a) Within thirty (30) days following receipt of the report of the Department Chairperson, the Credentials Committee shall examine evidence of the applicant’s education, medical/clinical knowledge, practice-based learning and improvement, systems-based practice, professionalism and character, patient care, professional competence, qualifications, communicative skills, prior behavior, and ability to work harmoniously with others, criminal history, if any, professional liability history, and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the Chairperson of the Department in which Privileges are sought, any comments or information concerning the applicant from any Member of the Medical Staff, in evaluating whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the Clinical Privileges requested.

(b) The Credentials Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of the applicant’s application, qualifications, or Clinical Privileges requested.

(c) The Credentials Committee may use the expertise of the Department Chairperson, or any member of the Department, or an outside consultant, if additional information is needed regarding the applicant’s qualifications when advisable because appropriate expertise is not readily available within the Medical Staff or because of the need to seek recommendations or advice of unrelated healthcare providers or non-Medical Staff healthcare providers who are not in direct competition with the applicant.

(d) As part of the process of making its evaluation and findings, the Credentials Committee may require an applicant currently seeking appointment to the Medical Staff, as a condition to making a finding that the applicant is qualified for appointment, to undergo a physical and/or mental examination by a Physician or
Physicians satisfactory to the Credentials Committee. The Credentials Committee may also require such an examination during the appointment period to aid it in determining whether Clinical Privileges should be continued. Further consideration of the application (which shall be deemed incomplete until such examination has been completed) shall cease until such time as the Credentials Committee has received the examination results and has had an opportunity to evaluate them and make a finding thereon. The report of such examination as to the applicant’s ability to perform the essential functions of the Clinical Privileges requested without posing a direct threat to the health or safety of patients, the applicant or otherwise and whether there is a need for an accommodation to the applicant to enable the applicant to perform such Privileges shall be made available to the Credentials Committee for its consideration. Failure of the applicant to undergo such an examination, without good cause, within sixty (60) days after being requested to do so in writing by the Credentials Committee, or failure of the applicant to make such report available to the committee, shall cause the application to be incomplete and constitute a voluntary withdrawal of the application for appointment and Clinical Privileges, and all processing of the application shall cease.

(e) If, during the processing of a Practitioner’s application for appointment, it becomes apparent to the Credentials Committee or its Chairperson that the committee is considering a recommendation that would deny appointment or deny or reduce any requested Clinical Privileges, the Chairperson of the Credentials Committee may (but shall not be obligated to) notify the Practitioner of the general tenor of the possible recommendation and ask if the Practitioner desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected Practitioner shall be informed of the general nature of the evidence supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this Policy with respect to hearings shall apply. Minutes of the discussion in the meeting shall not be kept. However, the Credentials Committee shall indicate as part of its report to the Medical Executive Committee whether such a meeting occurred.

(f) If the complete evaluation and recommendation of the Credentials Committee is delayed longer than thirty (30) days from receipt of the report of the Department Chairperson, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee and the CEO, explaining the reasons for the delay. If the Medical Executive Committee or the CEO determines that there has been an unnecessary delay in issuing a recommendation by the Credentials Committee, the Medical Executive Committee or CEO may require that a recommendation be made by a specific date.

(g) Following completion of its evaluation, the Credentials Committee shall determine whether the applicant is qualified for appointment to the Medical Staff in the category sought and for the Clinical Privileges requested. After considering
the information provided to it, the Credentials Committee shall prepare a written report of its findings as to the experience, training, competence and qualifications of the applicant and shall transmit its report, the application and accompanying information to the Medical Executive Committee. All evaluations shall address to the specific Clinical Privileges to be granted which may be qualified by any probationary or other conditions or restrictions, and whether the applicant is qualified for such Privileges.

2.B.5. Medical Executive Committee Procedure

(a) The Medical Executive Committee shall review the application and report of the Credentials Committee and accompanying information at its next regularly scheduled meeting.

(b) If the complete evaluation and recommendation of the Medical Executive Committee is delayed longer than thirty (30) days from receipt of the report of the Credentials Committee, the Chairperson of the Medical Executive Committee shall send a letter to the applicant, with a copy to the CEO explaining the reasons for the delay. If the CEO determines that there has been unreasonable delay in issuing a recommendation by the Medical Executive Committee, the CEO may require that a recommendation be made by a specific date.

(c) As part of its evaluation, the Medical Executive Committee may meet with the Chairperson of the Credentials Committee to discuss the recommendations and may:

(1) recommend to the Quality and Patient Safety Committee of the Board that the applicant be appointed and granted the Clinical Privileges requested, in whole or in part;

(2) refer the matter back to the Credentials Committee for additional research or information before making its recommendation to Quality and Safety Committee of the Board;

(3) request additional information from the applicant, including a physical or mental examination, as provided in subparagraph (d);

(4) or recommend to the Quality and Patient Safety Committee of the Board that it deny the application, in whole or in part.

(d) As part of the process of making its recommendation, the Medical Executive Committee may require the applicant as a condition to recommending appointment to undergo a physical and/or mental examination by a Physician or Physicians satisfactory to the Medical Executive Committee if not previously performed as required by the Credentials Committee. Further consideration of the application shall cease until such time as the Medical Executive Committee has received the examination results and has had an opportunity to evaluate them and make a recommendation thereon. The report of any such examination as to the
applicant’s ability to perform the essential functions of the Clinical Privileges requested without posing a direct threat to the health or safety of patients, the applicant or others and whether there is a need for an accommodation to the applicant to enable applicant to perform such Privileges shall be made available to the committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time not exceeding sixty (60) days after being requested to do so in writing by the Medical Executive Committee or failure of the applicant to make such report available to the committee shall cause the application to be incomplete and constitute a voluntary withdrawal of the application for appointment and Clinical Privileges, and all processing of the application shall cease.

(e) If the Medical Executive Committee finds that the applicant is otherwise qualified for appointment and the granting of the requested Privileges, the Medical Executive Committee through the Director of Medical Staff Services shall notify the applicant that its recommendation is favorable to the applicant but recommendation for appointment by the Quality and Patient Safety Committee of the Board is conditioned upon the applicant’s completion and delivery of a health status questionnaire in form approved by the Board of Directors and the responses contained therein. Such questionnaire shall be delivered to the Director of Medical Staff Services to be submitted to the Quality and Patient Safety Committee of the Board for review. The application shall be deemed incomplete and shall not be further processed until such questionnaire have been completed and so delivered by the applicant.

2.B.6. Meeting With Affected Applicant

If, during the processing of an applicant’s appointment application it becomes apparent to the Medical Executive Committee or its Chairperson that the committee is considering a recommendation that would deny appointment, deny or reduce any requested Clinical Privileges, the Chairperson of the Medical Executive Committee may (but shall not be obligated to) notify the applicant of the general tenor of the possible recommendation and ask if the applicant desires to meet with the Medical Executive Committee. At such meeting, the affected applicant shall be informed of the general nature of the committee’s concerns and any evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this Policy with respect to hearings shall apply. Minutes of the discussion in the meeting shall not be kept. However, the committee shall indicate as part of its report to the Quality and Patient Safety Committee of the Board whether such a meeting occurred.

2.B.7. Medical Executive Committee Recommendation

(a) If the Medical Executive Committee’s recommendation is to appoint the applicant and to grant the requested Clinical Privileges, the Medical Executive Committee shall make a written report and recommendation with respect to the applicant to the Quality and Safety Committee of the Board. All recommendations to appoint
shall also specifically recommend the Clinical Privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such Clinical Privileges, the Department Affiliation Medical Staff category. If the Medical Executive Committee’s recommendation differs from the findings of the Department Chairperson or the Credentials Committee, the report shall specifically state the reasons for such differences.

(b) If the Medical Executive Committee’s recommendation is adverse to the applicant and would entitle the applicant to appeal such recommendation and request a hearing pursuant to this Policy, such recommendation shall be forwarded to the CEO. The CEO shall promptly so notify the applicant by Special Notice. The application shall not be forwarded to the Quality and Patient Safety Committee of the Board until the applicant has exercised the right to a hearing as provided in this Policy and the procedure provided in this Policy has been completed or the applicant has been deemed to have waived the right to a hearing as provided in this Policy.

(c) If the Medical Executive Committee’s recommendation is to appoint the applicant but to grant only certain of the requested Clinical Privileges, the Medical Executive Committee shall make a written report and recommendation with respect to the applicant and those specific Privileges recommended to be granted, and also indicate those Privileges recommended not be granted, to the Quality and Patient Safety Committee of the Board through the President of the Medical Staff or his/her designee. As to the Clinical Privileges which the Medical Executive Committee has recommended not be granted, such recommendation shall be forwarded to the CEO who shall so notify the applicant by Special Notice of the recommendation and of his/her rights to a hearing in accordance with this Policy.

(d) If the Medical Executive Committee’s recommendation is unfavorable to the applicant and either the applicant has waived his/her rights to appeal such recommendation or, having exercised such right to appeal, the Hearing Panel, as described in Article 5 of this Policy, has rendered a decision supporting such adverse recommendation, and no further appeal has been requested pursuant to Section 5E or, if requested, has been completed and a decision supporting such adverse recommendation has been rendered, the Medical Executive Committee shall submit its recommendation to the Quality and Patient Safety Committee of the Board at its next regularly scheduled meeting at which the Quality and Patient Safety Committee of the Board shall make its recommendation to the Board of Directors for its final determination. If the application for appointment or request for Clinical Privileges is denied by the Board of Directors, in whole or in part, the applicant shall be notified by Special Notice and the provisions of Article 5 shall apply, which may entitle the applicant to appeal such action if not previously afforded such appeal rights as provided in Article 5.
2.B.8. **Quality and Patient Safety Committee of the Board Action**

(a) Except in the case of an adverse recommendation by the Medical Executive Committee and where an appeal thereof is pending, the President of the Medical Staff at the next scheduled meeting of the Quality and Patient Safety Committee of the Board shall present to such committee the recommendations of the Medical Executive Committee for appointment of the applicant to the Medical Staff and for the granting of Clinical Privileges. The Quality and Patient Safety Committee of the Board shall act upon the recommendations as to the application at such meeting and shall make its recommendation thereon to the Board of Directors; provided, however, the Board of Directors delegates the authority to render decisions on appointment and granting of Clinical Privileges to the Quality and Patient Safety Committee of the Board without referral to or action by the Board of Directors on applications which:

1. are complete;
2. have had no final recommendation from the Medical Executive Committee for appointment, reappointment or renewal or modification of Privileges that is adverse or with limitation;
3. have had no current challenge or previously successful challenge to licensure or registration;
4. have had no involuntary termination of medical staff appointment at this Hospital or another organization;
5. have had no involuntary limitation, reduction, denial, or loss of Privileges at this Hospital or another healthcare organization;
6. have had no voluntary or involuntary surrender of medical staff appointment or Clinical Privileges at any hospital which is based upon the conduct of the applicant or competency of the applicant or in exchange for any healthcare facility not initiating, or ceasing the conduct of, any investigation of the applicant’s conduct or competence; and
7. have had no adverse final judgment or arbitration award in a professional liability action within the appraisal/reappraisal period in which the Practitioner’s care or omission of care is a significant factor behind the claim or lawsuit.

(b) Upon receipt of recommendations from the Medical Executive Committee that the applicant be appointed with the Clinical Privileges requested or that the applicant be appointed but be granted only certain of the Clinical Privileges requested, the Quality and Patient Safety Committee of the Board shall review the recommendations of the Medical Executive Committee and the applicant’s responses to the health status questionnaire, may meet with the Medical Executive Committee Chairperson to discuss the recommendations, and shall:
(1) appoint the applicant and grant the recommended Clinical Privileges requested as to those applications meeting the criteria described in subparagraph (a);

(2) refer the matter for additional research or information including requesting advice from the Medical Executive Committee with respect to the applicant’s responses to the health status questionnaire;

(3) request additional information from the applicant, including a physical or mental examination as provided in subparagraph (c);

(4) reject the recommendations of the Medical Executive Committee;

(5) appoint the applicant but grant only a part of the Clinical Privileges requested; or

(6) refer the application to the Board of Directors for its consideration and action with or without any recommendation.

(c) As part of the process of making its evaluation, including review of applicable reports and the applicant’s responses to the health status questionnaire, the Quality and Patient Safety Committee of the Board may require an applicant seeking appointment, as a condition to further recommending appointment, to undergo a physical and/or mental examination by a Physician or Physicians satisfactory to the Quality and Safety Committee of the Board. The Quality and Patient Safety Committee of the Board may also require such an examination at any time during the appointment period to aid it in determining whether Clinical Privileges should be continued. Further consideration of the application (which shall be deemed incomplete until such examination has been completed) shall cease until such time as the Quality and Patient Safety Committee of the Board has received the examination results and has had a reasonable opportunity to evaluate them and, if applicable, make a recommendation thereon. Such examination and report shall evaluate the applicant’s ability to perform the essential functions of the Clinical Privileges requested without posing a direct threat to the health or safety of patients, the applicant or others and whether there is a need for an accommodation to the applicant to enable the applicant to perform such Privileges. Failure of the applicant to undergo such an examination, without good cause, within sixty (60) days after being requested to do so in writing by the Quality and Safety Committee of the Board, or failure of the applicant to make such examination report available to the Quality and Patient Safety Committee of the Board shall cause the application to be incomplete and constitute a voluntary withdrawal of the application for appointment. The Quality and Patient Safety Committee of the Board may request additional information or refer the matter or any specific issue back to the Executive Committee, Credentials Committee or the Department Chairperson for additional information before making its final decision.
(d) If the Quality and Patient Safety Committee of the Board initially determines to reject the favorable recommendations of the Executive Committee or a portion of such recommendation, it shall discuss this matter with the Chairperson of the Executive Committee prior to making its final recommendation. If the Quality and Patient Safety Committee of the Board determination is still unfavorable to the applicant, it shall make no final decision but shall refer such matter to the Board of Directors with its unfavorable recommendation, provided, however, if any portion of the Committee’s decision is favorable to the applicant in granting appointment and as to a portion of the requested Privileges, it shall appoint the applicant and grant such approved portion of the Clinical Privileges requested.

(e) If appointment is approved by the Committee as to those applications for which authority was delegated, the CEO, or his/her designee, acting on behalf of the Board of Directors, shall so inform the applicant, the Chairperson of the applicable Department, and the Chairpersons of the Medical Executive and Credentials Committee of such decision. Such notice shall include the Clinical Privileges approved, the Department affiliation and the Medical Staff category to which the applicant was appointed, any special conditions attached to the appointment and that monitor(s) shall be assigned to observe his/her performance. The CEO shall also apprise the appointee of all rules, regulations and restrictions specific to the assigned Department in order to assist the appointee in completion of any provisional period.

2.B.9. Board of Directors’ Action

(a) In the event an application does not satisfy the requirements for Quality and Patient Safety Committee of the Board review as set forth in Section 2.B.7(a) or the Quality and Patient Safety Committee of the Board defers taking action to the Board, the President of the Medical Staff at the next scheduled meeting of the Board of Directors shall present to the Board of Directors the recommendations of the Medical Executive Committee and the Quality and Patient Safety Committee of the Board as to the appointment of the applicant to the Medical Staff and for the granting of Clinical Privileges. Where the Quality and Patient Safety Committee of the Board has either merely reviewed an application because it is not eligible for its delegated authority or it has deferred action on an application and referred it to the Board of Directors for action, the Chairperson of the Quality and Patient Safety Committee of the Board shall present the application with the evaluation of the committee and any recommendation to the Board of Directors for the Board of Directors’ action thereon. The Board of Directors shall act upon the recommendations as to the application at such meeting.

(b) Upon receipt of recommendations from the Medical Executive Committee or the Quality and Patient Safety Committee of the Board that the applicant be appointed with the Clinical Privileges requested, the Board of Directors shall review the recommendations of the Medical Executive Committee and the applicant’s responses to the health status questionnaire, may meet with the Medical Executive Committee Chairperson to discuss the recommendations, and shall:
(1) appoint the applicant and grant the recommended Clinical Privileges requested;

(2) refer the matter for additional research or information including requesting advice from the Medical Executive Committee with respect to the applicant’s responses to the health status questionnaire;

(3) request additional information from the applicant, including a physical or mental examination as provided in subparagraph (c);

(4) reject the recommendations, or

(5) appoint the applicant but grant only a part of the Clinical Privileges requested.

If the initial decision of the Board of Directors is to reject a favorable recommendation of the Medical Executive Committee or the Quality and Patient Safety Committee of the Board or a portion thereof, it shall first discuss its initial determination with the Chairperson of the Medical Executive Committee or Quality and Patient Safety Committee of the Board prior to taking further action. If the Board of Directors’ determination is still unfavorable to the applicant, it shall make no final decision until the applicant has been informed of such recommendation by Special Notice and has exercised the rights to a hearing and appeal as outlined in this Policy and the procedure provided for in this Policy has been completed or the applicant has been deemed to have waived those rights, provided, however, if any portion of the Board of Directors’ initial decision is favorable to the applicant in granting appointment and as to a portion of the requested Privileges, the Board of Directors shall take final action as to such approved portion.

(c) As part of the process of making its evaluation, including review of applicable reports and the applicant’s responses to the health status questionnaire, the Board of Directors may require an applicant seeking appointment, as a condition to granting appointment, to undergo a physical and/or mental examination by a Physician or Physicians satisfactory to the Board of Directors if not previously required by the Credentials Committee, Medical Executive Committee or the Quality and Safety Committee of the Board. The Board of Directors may also require such an examination during any appointment period to aid it in determining whether Clinical Privileges should be continued. Further consideration of the application (which shall be deemed incomplete until such examination has been completed) shall cease until such time as the Board of Directors has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon. The report of such examination as to the applicant’s ability to perform the essential functions of the Clinical Privileges requested without posing a direct threat to the health or safety of patients, the applicant or others and whether there is a need for an accommodation to the applicant to enable the applicant to perform such Privileges
shall be made available to the Board of Directors for its consideration. Failure of the applicant to undergo such an examination without good cause within sixty (60) days after being requested to do so in writing by the Board of Directors, or failure of the applicant to make such report available to the Board of Directors shall cause the application to be complete and constitute a voluntary withdrawal of the application for appointment. The Board of Directors may request additional information or refer the matter or any specific issue back to the Medical Executive Committee, Credentials Committee or the Department Chairperson for additional information before making its final decision.

(d) Upon receipt of a recommendation from the Medical Executive Committee that the applicant be appointed but be granted only certain of the Clinical Privileges requested but not all, the Board of Directors shall review the recommendations of the Medical Executive Committee as to the Privileges recommended to be granted and the applicant’s responses to the health status questionnaire, may meet with the Executive Committee Chairperson to discuss the recommendations, and shall:

(1) appoint the applicant and grant the recommended Clinical Privileges (without taking action as to those Clinical Privileges for which a recommendation not to grant was made and as to which the applicant is entitled to a hearing until the appeal process provided in this Policy shall have been completed or the applicant is deemed to have waived such rights);

(2) request additional information or refer the matter to the Medical Executive Committee or the Quality and Patient Safety Committee of the Board for additional research or information; or

(3) initially decide to reject a favorable recommendation of the Executive Committee and the Quality and Patient Safety Committee of the Board or a portion thereof, provided, however, it shall first discuss this matter with the Chairperson of the Medical Executive Committee or the Quality and Patient Safety Committee of the Board prior to taking further action. If the Board of Director’s determination is still unfavorable to the applicant, it shall make no final decision until the applicant has been informed of such recommendation by Special Notice and has exercised the rights to a hearing and appeal as outlined in this Policy and the procedure provided for in this Policy has been completed or the applicant is deemed to have waived those rights, provided, however, if any portion of the Board of Director’s initial decision is favorable to the applicant in granting appointment and as to a portion of the requested Privileges, it shall take final action as to such approved portion.

(e) Upon receipt of a recommendation from the Medical Executive Committee or the Quality and Patient Safety Committee of the Board that the applicant be denied appointment and the applicant has either waived his or her right to appeal such recommendation and to a hearing thereon, or has requested such hearing and
appealed such recommendation and the process described in Article 5 has been completed and such recommendation is still adverse to the applicant, the Board of Directors shall review the recommendations of the Medical Executive Committee or the Quality and Patient Safety Committee of the Board as to the application which has been recommended be denied, may meet with the Executive Committee Chairperson or the Chairperson of the Quality and Safety Committee of the Board, and shall:

1. agree with such adverse recommendation and deny appointment to the Medical Staff and the Clinical Privileges requested;

2. request additional information or refer the matter to the Quality and Patient Safety Committee of the Board or the Medical Executive Committee for additional research or information; or

3. if the initial decision of the Board of Directors is to approve the adverse recommendation of the Medical Executive Committee or the Quality and Safety Committee of the Board, it shall first discuss its initial determination with the Chairperson of the applicable committee (or both if both such committees are in agreement as to the adverse recommendation) prior to taking further action. If the Board of Directors’ determination is favorable to the applicant and, therefore, contrary to the recommendation of the Medical Executive Committee and/or the Quality and Safety Committee of the Board, it may nonetheless decide to appoint the applicant and grant the Clinical Privileges requested.

(f) If appointment is approved by the Board of Directors, the CEO or his/her designee, acting on behalf of the Board of Directors, shall so inform the applicant and the Chairperson of the Department of the decision.

2.C. PROVISIONAL STATUS

2.C.1. Duration of Initial Provisional Staff Appointment and Clinical Privileges

(a) All initial appointments to the Medical Staff, except Honorary, Consulting and Affiliate Staff categories, shall be to the Provisional Staff and the granting of all initial and additional Clinical Privileges shall be provisional, for a period of up to twenty-four (24) months from the date of the appointment or grant of Clinical Privileges (which period may be extended by the Board of Directors upon the recommendation of the Medical Executive Committee).

(b) Upon approval by the Board of Directors, the Practitioner shall be appointed a proctor within his/her discipline, if possible. The proctor will be responsible for the evaluation of the Practitioner’s provisional monitoring requirements as set forth by their Department. The proctor will provide feedback to the Practitioner during the evaluation and provide a written summary to the Practitioner and the Chairperson of the Department at the completion of the evaluation. The evaluation will be completed within the first eighteen (18) months of privileges to
allow adequate time for review and recommendations prior to the end of the twenty-four (24) month provisional period.

(c) During the term of Provisional Staff appointment and/or provisional grant of Clinical Privileges, the Practitioner shall be evaluated by the Chairperson of the Department or Departments in which the Practitioner has Clinical Privileges, and by the relevant committees of the Medical Staff as to clinical competence and by the Hospital as to the Practitioner’s general behavior and conduct in the Hospital. Provisional Staff appointees have eighteen (18) months to complete their provisional monitoring and if so completed, they shall be assigned to the applicable Medical Staff category in accordance with the Bylaws. At the time of provisional monitoring review, ongoing professional performance evaluation data will be provided to the reviewers. If the applicant has not completed his/her provisional monitoring within the stated time, the Credentials Committee may extend the period to twenty-four (24) months. If the provisional monitoring is not completed within twenty-four (24) months, the applicant will have his/her privileges and membership terminate, if the practitioner does not have adequate activity to evaluate clinical competence.

(d) Provisional Clinical Privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted.

(e) Continued appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment, (e.g. ongoing professional performance evaluation data, etc.).

2.C.2. Duties of Members

(a) Appointment to the Medical Staff shall require that each Practitioner assume such reasonable duties and responsibilities as the Board of Directors or the Medical Staff shall require, including but not limited to those set forth in the Bylaws.

(b) During the term of Provisional Staff appointment or provisional grant of Clinical Privileges, a Practitioner may exercise all of the prerogatives of the Medical Staff commensurate with the Provisional Staff but must demonstrate that he or she meets all of the qualifications and must fulfill all of the obligations attendant to the Provisional Staff.

(c) Each Practitioner must arrange, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed/observed by the Department Chairperson and/or designated proctors, if any.

(d) Failure of a provisional appointee to fulfill all requirements of the Provisional Staff or provisional status of additional Privileges granted, if any, completion of medical records, completion of provisional monitoring, and cooperation with peer review, as outlined in this Policy, the Medical Staff Rules and Regulations and other Medical Staff policies shall render the provisional appointee ineligible to apply for reappointment. In that event, at the expiration of the term of the
Provisional Staff appointment, all Clinical Privileges will terminate. The Practitioner may be permitted to reapply, after the expiration of at least three (3) years, for initial appointment, in accordance with this Policy.

2.D. CLINICAL PRIVILEGES

2.D.1. General

(a) Neither Medical Staff appointment nor reappointment shall confer any Clinical Privileges or right to practice at the Hospital. Each Practitioner who has been appointed to the Medical Staff shall be entitled to exercise only those Clinical Privileges specifically granted by the Board of Directors.

(b) The grant of Clinical Privileges shall carry with it acceptance of the obligations of such Privileges including emergency department and other rotational obligations as set forth in the Bylaws and as determined by the Member’s Department.

(c) The Clinical Privileges recommended to the Board of Directors shall be based upon consideration of the following:

1. the existence of criteria for the requested Clinical Privileges which have been approved by the Board of Directors;

2. the applicant’s ability to meet all Medical Staff and Board of Directors criteria for the requested Clinical Privileges;

3. the applicant’s relevant education, training, experience, demonstrated current clinical competence and clinical judgment, patient care, medical/clinical knowledge, practice based learning and improvement, professionalism, interpersonal and communicative skills, systems-based practice, references, recommendations of peers, current licensure, utilization patterns, and ability to perform the essential functions of the Privileges requested, with or without reasonable accommodation, without posing a direct threat to the health or safety of the applicant, patients or others;

4. recommendations and evaluations received from the applicant’s peers and peer review evaluations, if any, from other hospitals;

5. availability of qualified Physicians or other appropriate Members to provide medical coverage for the applicant in case of the applicant’s illness or unavailability;

6. adequate levels of professional liability insurance coverage with respect to the Clinical Privileges requested;

7. the Hospital’s available resources and personnel;
any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;

any information concerning the voluntary or involuntary termination of medical staff appointment or the voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another hospital;

any information concerning current or recent professional liability claims involving the Practitioner;

whether the Hospital has determined to perform the procedures relating to the Clinical Privileges sought by the applicant;

whether the Privileges are the subject of any exclusive contractual arrangements of the Hospital; and

other relevant information, including, but not limited to, a written report and findings by the Chairperson of each of the Departments in which such Privileges are sought and report from The National Practitioner Databank.

The applicant shall have the burden of establishing that he/she satisfies the requirements for, and has the competence to exercise, the Clinical Privileges requested.

The reports of the Chairperson of the Department in which Privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for Medical Staff appointment.

2.D.2. Clinical Privileges for Dentists

(a) The scope and extent of surgical procedures that a Dentist may perform in the Hospital shall be delineated and recommended in the same manner as other Clinical Privileges.

(b) Surgical procedures performed by Dentists shall be under the overall supervision of the Chairperson of the Department of Surgery. All dental patients shall receive the same basic medical appraisals as patients admitted to other surgical services. Histories and physical examinations may be performed by an oral surgeon on patients with no significant medical history or problems, otherwise the medical history and physical examination of the patient shall be made and recorded by a Physician Member of the Medical Staff or by an Advanced Practice Registered Nurse acting within the scope of a collaborative practice agreement with the Medical Staff Member before dental surgery shall be scheduled for performance. A designated Physician Member of the Medical Staff shall be responsible for the medical care of the patient throughout the period of hospitalization.
2.D.3. Clinical Privileges for Podiatrists

(a) The scope and extent of surgical or medical procedures that a Podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other Clinical Privileges.

(b) Surgical procedures performed by Podiatrists shall be under the overall supervision of the Chairperson of the Department of Orthopedics. A podiatrist who admits a patient may complete an admission history and physical examination and assess the medical risks of the procedure to the patient without the assistance of a physician on the Medical Staff.

(c) The Podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and podiatric physical examination as well as all appropriate elements of the patient’s record. Podiatrists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations, and in compliance with the Hospital and the Bylaws and this Policy.

2.D.4. Residents in Training

The Montana Family Medicine Residency Program is an approved residency program affiliated with the Hospital. Residents will complete rotations for their first, second and third years. Residents will be in temporary attendance at the Hospital in a training capacity. They are not considered Members of the Medical Staff nor are they granted Privileges. Residents may not admit or discharge patients except under the direct supervision of an Active Staff preceptor with admitting Privileges within their approved scope of practice. The resident’s scope of practice and ability to write orders will be determined jointly by the Director of the Residency Program and Members of the Medical Staff participating in the residency program, approved by the Medical Executive Committee and outlined in a Hospital or Medical Staff policy. Medical Staff Members have the option of not participating in the teaching program without jeopardizing their Privileges or appointment. Residents will be provided with a copy of the Bylaws and Medical Staff Rules and Regulations and informed of pertinent Hospital policies and procedures through appropriate orientation and shall be required to comply with such requirements. Medical records completion and authentication will be in accordance with Medical Record Requirements of the Medical Staff Rules and Regulations.

2.D.5. Limitations on Granting Privileges

Privileges shall not be granted to any Practitioner which will conflict with any restrictions or limitations upon the exercise of the requested Privileges created by any Medical Staff Development Plan, Hospital contractual arrangements with one or more Practitioners, or
Department or Section which has been closed by the Board of Directors. In the event any Practitioner ceases to be affiliated with any group with which the Hospital has an exclusive contracted arrangement, the Clinical Privileges of such Practitioner shall immediately terminate without any rights to appeal or a hearing thereon which might otherwise be provided herein. Further, the Clinical Privileges of the members of any group with which the Hospital has an exclusive contractual arrangement which is terminated, and the Hospital thereafter enters into another such exclusive contractual arrangement with another group, shall automatically terminate without any right of appeal or hearing thereof which would otherwise be provided in this Policy.


(a) Application for Additional Clinical Privileges:

Whenever during the term of a Member’s appointment (including at the time of reappointment) to the Medical Staff, additional Clinical Privileges are desired, the Member requesting additional Privileges shall apply in writing therefore to the CEO or his/her designee. The application shall state in detail the specific additional Clinical Privilege(s) desired and the Member’s relevant recent education, training and experience which justify such requested additional Privileges. This application shall be transmitted by the CEO to the appropriate Department Chairperson. Thereafter, it will be processed in the same manner as an application for initial Clinical Privileges.

(b) Factors to be Considered:

Recommendations for additional Clinical Privileges shall be based upon:

(1) relevant recent training, education or experience;

(2) review of aggregate data of patient activity in this or other hospitals;

(3) results of the Hospital’s monitoring review activities, including peer review, as applicable;

(4) recommendations and evaluations received from the Member’s peers;

(5) whether the applicant meets the qualifications and criteria for the Clinical Privileges;

(6) whether the performance of such procedures contemplated by the requested Privileges would conflict with any contractual arrangements of the Hospital or with a specific Department or any restricted or closed Department(s);

(7) other reasonable indicators of the Member’s continuing qualifications for the Privileges in question; and
any other factors which would be considered in the initial granting of Clinical Privileges, including the report of the National Practitioner Databank.

The recommendation for additional Privileges may carry with it such requirements for supervision or consultation or other conditions as are thought necessary by the Credentials Committee, Medical Executive Committee or the Board of Directors.


(a) Initiation of Action:

Requests for Clinical Privileges to perform a procedure which is not then being performed at the Hospital and for which credentialing criteria have not previously been approved by the Board of Directors shall, if the procedure is not considered experimental, first be forwarded to the appropriate Department Chairperson. The Department Chairperson shall evaluate whether the procedure is one which is commonly part of the curriculum of a residency or fellowship (a “general procedure”) or which generally requires special training or education outside or beyond a residency or fellowship (a “special procedure”).

Procedure for General Procedures:

If the Department Chairperson determines that the procedure is a general procedure and training to perform the procedure should be obtained through a residency and fellowship training program, the Department Chairperson may recommend addition of the procedure to the delineation of Privileges list related to such specialty with appropriate documentation that the following items were considered and included in the Department Chairperson’s recommendation:

(1) Financial considerations, including the advisability, efficiency and cost of the procedure or expanded scope of care, as to which matters the Department Chairperson shall consult with and seek input from Hospital administration;

(2) Criteria to be used for privileging:

(3) Appropriate input from risk management, the Performance Excellence Department (or its successor as it may be renamed), nursing and other support services which would be involved (i.e., laboratory, radiology, physical therapy, etc.); and

(4) A mechanism for monitoring and evaluating clinical performance and outcomes.

If the Department Chairperson determines that such procedure shall be added to the delineation of Privileges list related to such specialty, it shall forward its
recommendation and supporting documentation to the Chairperson of the Credentials Committee.

(b) Procedure for Special Procedures:

If the Department Chairperson determines that the procedure is a special procedure or if the procedure is likely to be performed by more than one specialty, an ad hoc committee appointed by the Chairperson of the Credentials Committee, with representation by all specialties involved, shall evaluate and establish appropriate criteria for privileging such procedure.

The ad hoc committee’s recommendation shall be in writing and must include:

(1) Financial considerations, including the advisability, efficiency and cost of the special procedure or expanded scope of care, as to which matters the Department Chairperson shall consult with and seek input from Hospital administration;

(2) Establishment of criteria for privileging, including the advisability and extent to which proctoring and/or monitoring is required;

(3) A literature search will be conducted to outline indicators for use, results, complication rates, and other pertinent information reported. The ad hoc committee will forward this information to the Credentials Committee, Performance Excellence Department (or its successor as it may be renamed), and responsible Department Chairperson(s) for information;

(4) Input from risk management and the Performance Excellence Department (or its successor as it may be renamed) will be considered;

(5) Establishment of mechanisms to monitor and evaluate clinical performance and outcomes of all new procedures; and

(6) The ad hoc committee shall determine who will be responsible for coordinating how the special procedure will interface with other services, i.e., nursing, radiology, lab and ancillary support services.

Following completion of its analysis, the ad hoc committee shall prepare its report in writing of its findings and recommendations, which will be sent to the Department Chairperson(s) involved for their review and consideration and submission to their respective Departments as a whole for review and consideration. Each Department shall evaluate the ad hoc committee’s recommendation and submit its recommendations to the Chairperson of the Credentials Committee.

(c) Transmittal of Proposed Criteria:
The Chairperson of the Credentials Committee will transmit the proposed standards from the Department Chairperson (for general procedures) or from the ad hoc committee and respective Departments (for special procedures or those involving more than one clinical specialty) to the Credentials Committee for further consideration.

(d) Action by Credentials Committee:

After evaluation, the Credentials Committee will send its written recommendation on the proposed criteria to the Executive Committee.

(e) Action by Medical Executive Committee:

The Medical Executive Committee, after evaluation of such proposed criteria, will make its recommendation in writing to the Board of Directors for review and approval in the same manner as approval of credentialing criteria generally.

(f) Action by Board of Directors:

The Board of Directors shall review the proposed criteria and recommendations and shall approve, reject or request further review or information of such proposed criteria. Upon receipt of criteria acceptable to the Board of Directors, the Board of Directors shall consider such criteria for final approval.

(g) Applicability of Criteria:

If approved, the approved criteria shall apply to any applicant or current Member who wishes to exercise the Privilege to perform the new procedure who must demonstrate satisfaction of the required training, education, experience and competency.

2.D.8. Emergency Clinical Privileges

(a) An “emergency” shall mean a patient’s condition or set of circumstances in which the life of a patient is in immediate danger, or in which serious harm is likely to result to the patient and in which any delay in administering treatment would increase the danger to the patient’s life or could result in serious or permanent harm. When such an emergency situation no longer exists, the patient shall be assigned to an appropriate Member of the Medical Staff.

(b) In case of an emergency, a Medical Staff Member attending a patient shall be expected and permitted to do everything in his/her power to save the life of the patient or to reduce the risk of permanent or serious harm to the degree permitted by his/her license, including requesting such consultations as may be available, regardless of his/her Medical Staff status, Department affiliation or privileges. This duty shall be subject to the Medical Staff Member’s concurrent duty to take into account or abide by a patient’s directive under Montana law to withhold or
withdraw life-sustaining procedures, or to take into account or abide by the requirements of sound medical practice.

2.E. PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

2.E.1. Temporary Clinical Privileges for Applicants

(a) Temporary Privileges shall not routinely be granted to applicants except in such extraordinary situations as the CEO (or his/her designee), President of the Medical Staff and the Chairperson of the applicable Department in which Privileges are sought determine (1) are necessary to fulfill an important patient care, treatment and service need, (2) to avoid undue hardship to the Hospital or the Medical Staff (e.g., in extraordinary situations when necessary to avoid critical shortages in Physician staffing of specific practice areas of the Hospital), or (3) is otherwise in the best interest of the Hospital. In such cases, the CEO or his/her designee may grant temporary admitting and/or Clinical Privileges to an applicant for a specific time period not exceeding ninety (90) days, upon receipt of a completed application for Medical Staff appointment and after making inquiry to the National Practitioner Data Bank (and receipt of the response therefrom), verifying information as to the licensure, Federal DEA certification, if applicable, competence, character, ethical standing (including, but not limited to, determining whether the applicant has been excluded from the Medicare, Medicaid or other government sponsored healthcare program), verifying professional liability insurance coverage, receipt of the favorable recommendation of the Chairperson of the applicable Department, and after consulting with the President of the Medical Staff and receiving the favorable recommendation thereof.

(b) In all cases only applicants who have no current or previously successful challenge to licensure or registration, have no adverse criminal history, have not been subject to involuntary termination of medical staff membership or Clinical Privileges at another healthcare organization, have not been subject to involuntary limitation, reduction, denial, or loss of Clinical Privileges, have no unusual pattern of or excessive number of professional liability actions or claims, whether currently pending, having resulted in final judgments or arbitration awards against the applicant or settlements, shall be considered for the granting of temporary Privileges.

(c) For good cause shown the CEO may extend such temporary admitting and Clinical Privileges to an applicant for an additional period not to exceed ninety (90) days.

(d) In exercising such Privileges, the applicant shall act under the supervision of the Chairperson of the Department in which the applicant has requested primary Privileges.
(e) The CEO shall in each case first obtain such Practitioner’s signed acknowledgment to be bound by all bylaws, policies, and rules and regulations of the Medical Staff and Hospital in all matters relating to temporary Clinical Privileges.

2.E.2. Temporary Clinical Privileges for Teaching Privileges and Critical Shortages

Except for disaster Privileges as provided in Section 2.E.4, temporary Clinical Privileges for care of a specific patient or patients when deemed necessary for patient care by the President of the Medical Staff or CEO (or his/her designee) or for a specified period not in excess of five (5) days with respect to a Practitioner whose request is for the purpose of teaching Members as to a procedure or new device may be granted by the CEO or his/her designee with the concurrence of either the Chairperson of the Department concerned or the President of the Medical Staff to a Practitioner who is not an applicant for appointment, in the same manner and upon the same conditions as set forth in Section 2.E.1. In addition, temporary Clinical Privileges may be granted by the CEO or his or her designee in extraordinary situations when necessary to avoid critical shortages in Physician staffing of specific practice areas of the Hospital from time to time. In all circumstances granting of such temporary Privileges shall be conditioned upon receipt of an appropriate application and after making inquiry to the National Practitioner Data Bank (and receipt of the response therefrom), verifying information as to the Montana licensure, DEA certification, if applicable, competence, character, ethical standing and professional liability insurance coverage, and receipt of the favorable recommendation of the Chairperson of the applicable Department. The CEO shall in each case first obtain such Practitioner’s signed acknowledgment to be bound by all bylaws, policies, and rules and regulations of the Medical Staff and Hospital in all matters relating to temporary Clinical Privileges. Such Privileges shall be restricted to the specific patient(s) or periods for which they are granted or for teaching as provided above.

2.E.3. Temporary Clinical Privileges for Members

Temporary Privileges for the performance of a specific procedure for a specific patient may be granted by the CEO and President of the Medical Staff to any Member when the failure to do so could jeopardize the health or safety of a patient. Such temporary Privileges must be within the specialty of the Member and be one which the Member would otherwise be expected to perform based upon the Member’s education, training, experience and other Clinical Privileges. For example, temporary Privileges may be granted to a Member to perform a procedure which the Member inadvertently omitted requesting at the time of appointment or reappointment and the process for applying for and being granted such additional privilege, or locating another Member with appropriate Privileges, is not practical because the delay in obtaining the availability of another Member with such Privileges would jeopardize the health and safety of a patient. Immediately after completion of the procedure by the Member, the Member shall apply for such additional Privileges in the manner herein set forth for applying for additional Privileges. In all circumstances granting of such temporary Privileges shall be conditioned upon receipt of an appropriate application and after making inquiry to the National Practitioner Data Bank (and receipt of the response therefrom), verifying
information as to the Montana licensure, DEA certification, if applicable, competence, character, ethical standing and professional liability insurance coverage, and receipt of the favorable recommendation of the Chairperson of the applicable Department.

2.E.4. Disaster Privileges for Physicians, Dentists and Podiatrists

(a) Appropriate temporary Privileges may be granted by the CEO, President of the Medical Staff or any designee thereof to any Physician, Dentist or Podiatrist who is not an applicant for Clinical Privileges in the case of a disaster when the Hospital has activated its Emergency Operations Plan and is unable to otherwise meet immediate patient needs upon presentation thereto of a valid picture ID issued by a state, federal or regulatory agency (e.g., a driver’s license or passport), AND any of the following:

(1) a current picture hospital ID card that clearly identifies professional designation,

(2) a current license to practice,

(3) primary source verification of the license,

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

(5) 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), or

(6) identification by current Hospital personnel or Medical Staff Member(s) who possess personal knowledge regarding the provider’s identity and ability to act as a licensed independent practitioner.

Any such Physician, Dentist or Podiatrist granted disaster Privileges shall have assigned thereto a Physician, Dentist or Podiatrist Member, as applicable, to directly observe the care provided by such Physician, Podiatrist or Dentist receiving disaster Privileges. When such disaster has ended and patient care may adequately be provided by Hospital’s providers, such disaster Privileges shall expire.

(b) The CEO or his/her designee will make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours as to whether to continue the disaster Privileges initially granted.
(c) Steps shall be taken to credential a Practitioner, to a similar extent as for temporary Privileges, as soon as the immediate situation is under control, or within 72 hours, whichever occurs first.

(d) All patient cases involving the Practitioner will be reviewed retrospectively by a Member of the Medical Staff.

2.E.5. Special Requirements

Special requirements of supervision and reporting may be imposed by the Department Chairperson concerned on any Practitioner granted temporary Clinical Privileges. Temporary Privileges shall be immediately terminated by the CEO or a designee upon notice of any failure by the Practitioner to comply with such special conditions.

2.E.6. Termination of Temporary Clinical Privileges

(a) The CEO may terminate temporary Privileges at any time after receiving a recommendation from the President of the Medical Staff or the Chairperson of the Department responsible for the Practitioner’s supervision. Clinical Privileges shall then be terminated when the Practitioner’s inpatients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the Practitioner granted temporary Privileges, a termination of temporary Clinical Privileges may be imposed by the CEO, the Department Chairperson or the President of the Medical Staff, and such termination shall be immediately effective.

(b) The appropriate Department Chairperson or the President of the Medical Staff shall assign to a Medical Staff Member responsibility for the care of the terminated Practitioner’s patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(c) The granting of any temporary admitting and Clinical Privileges is a courtesy on the part of the Hospital. Neither the granting, denial or termination of such Privileges, shall entitle the Practitioner involved to a hearing or any of the procedural rights provided in this Policy unless otherwise required by applicable law.

(d) Temporary Privileges shall be terminated automatically at any time the Credentials Committee or the Medical Executive Committee recommends not to appoint the applicant or at any time the application is withdrawn or deemed to be withdrawn. Similarly, at the Medical Executive Committee’s discretion, temporary Clinical Privileges shall be modified to conform to the recommendation of the Executive Committee that the applicant be granted permanent Privileges different from the temporary Privileges.
2.E.7. Rights Associated With Temporary, Locum Tenens, Emergency and Disaster Privileges

The granting of temporary, locum tenens, emergency or disaster Privileges shall not confer Medical Staff appointment on any Practitioner, nor shall Practitioners holding such Privileges be considered to be Members of the Medical Staff or have any of the rights provided to Medical Staff Members by this Policy, the Bylaws or otherwise except as expressly stated herein.

2.F. PROCEDURE FOR REAPPOINTMENT

2.F.1. General

All terms, conditions and procedures relating to initial appointment apply to a Member’s ongoing appointment and Clinical Privileges and to reappointment.

2.F.2. Application

(a) Each current Member who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form recommended by the Medical Executive Committee and approved by the Board of Directors. Such application shall request information similar to that requested upon initial application and such additional information as may be applicable with respect to a Member. To be eligible to apply for reappointment, a Practitioner must:

(1) have satisfied meeting attendance requirements, if any, set forth in the Bylaws;

(2) have met all Medical Staff responsibilities (including payment of Medical Staff dues applicable to the Practitioner) and fulfilled all duties including those assigned by the applicable Department Chairperson in the previous appointment term;

(3) have completed 50 Category I hours of continuing medical education during the previous two (2) years for reappointment or if 50 CME are not available; documented completion of residency or fellowship within the past two (2) years. At least 50% of the CME units must be in the physician’s area of specialty. Documentation will be submitted to the medical staff office and reviewed by department chairs at time of reappointment.

If a physician has not completed the required number of CME units, he/she will be required to submit a written plan, within 30 days of reappointment approval, of how he/she plans to fulfill this requirement within six months. Upon receipt of this written plan, physician will be notified that failure to meet this requirement within six months will be considered a voluntary resignation from the medical staff.
If after the six-month time period, the physician has not completed the required CME, he/she will be notified that failure to meet the CME requirement for medical staff membership has resulted in a voluntary resignation from the medical staff; and

(3) have continued to meet all qualifications and criteria outlined in the Bylaws and Hospital bylaws, policies and rules and regulations applicable to the Medical Staff category to which the previous appointment was made unless the Member requests modification of the Member’s Medical Staff category.

(b) At least one hundred and twenty (120) days prior to the expiration date of the appointment of each Member of the Medical Staff, except Honorary Staff, the Director of Medical Staff Services or his/her designee shall provide each Member with an application form for reappointment. Each Member, except members of the Honorary Staff, who desires reappointment, shall, at least ninety (90) days prior to such expiration date, complete such form and return it to the Director of Medical Staff Services. Failure to return the completed form at least ninety (90) days prior to such expiration date, without good cause, shall result in automatic termination of appointment at the expiration of the current appointment term. Further, failure to provide any new, additional or clarifying information or documentation promptly after request any time during the evaluation process so that the reappointment process is not delayed, may result in automatic expiration of the Member’s appointment and Clinical Privileges at the end of the then current appointment period if the reappointment process cannot otherwise be completed by such date. Incomplete applications will not be processed. An application shall be deemed to be complete when all questions on the application have been answered, all supporting documentation has been supplied and all information verified as necessary. Any application that continues to be incomplete sixty (60) days after the Member has been notified of the need for information shall be deemed to be withdrawn resulting in the Member’s appointment expiring at the end of the Member’s term. An application shall become incomplete if the need arises for new, additional or clarifying information any time during the evaluation. If an application for reappointment is submitted to the Hospital in a timely fashion and all additional requested documentation or information, if any, has been promptly submitted but because of delay in processing or timing of meetings of reviewing committees it is unlikely that the Board of Directors (or committee thereof), in normal course, will have acted on it prior to the expiration of the Member’s current term of appointment, the Board of Directors (or committee thereof) MAY approve the application and grant reappointment for a period not exceeding ninety (90) days. In such event, the Member shall be required to submit an additional application (or such supplemental application as may be developed) for consideration for further reappointment which shall be processed as provided in this Policy in the same manner as all other applications for reappointment.
(c) The Member shall have the same burden of producing information as an applicant for initial appointment as described in Section 2.B.2(e).

(d) The application shall be initially processed in the same manner as the application for initial appointment.

(e) Reappointment, upon the expiration of a Member’s current appointment period, if granted by the Board of Directors, to any category of the Medical Staff (other than Honorary) shall be for a period of up to, but not exceeding, two years; provided, however, the Board of Directors may reappoint any applicant for a period of less than two years at its discretion, including for the reason set forth in subparagraph (b) of this Section 2.F.2.

2.F.3. Factors to be Considered

The following factors shall be considered in determining the qualifications of a Member for reappointment to the Medical Staff:

(a) satisfaction of the qualifications for initial appointment set forth in Section 2.A.2(a);

(b) ethical behavior, clinical competence, professional conduct, clinical judgment and clinical and technical skills in the treatment of patients;

(c) compliance with the ethical standards of his/her profession;

(d) participation in Medical Staff, departmental and committee meetings and in Medical Staff duties;

(e) compliance with the Hospital’s bylaws and policies, including this Policy, and with the Bylaws and Medical Staff Rules and Regulations applicable to the Medical Staff category to which reappointment is requested;

(f) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care and the orderly operation of the Hospital, including cooperation with Hospital administration, and general attitude toward patients, the Hospital and its personnel;

(g) behavior at any other hospital at which the Member has Clinical Privileges, including cooperation with members of such hospital’s medical staff and hospital personnel as it relates to patient care and the orderly operation of the hospital including cooperation with that hospital’s administration, and general attitude toward patients, such hospital and its personnel;

(h) use of the Hospital’s facilities for patients, taking into consideration the Member’s comparative utilization patterns;
ability to perform the essential functions of the Clinical Privileges requested, with or without reasonable accommodation, without posing a direct threat to the health or safety to the Member, patients or others;

capacity to satisfactorily treat patients as indicated by the results of the Hospital’s quality assessment activities, evaluation functions, peer review or other reasonable indicators of continuing qualifications;
satisfactory completion of such continuing education requirements as may be imposed by law, this Policy, the Bylaws, the Medical Staff or applicable accreditation agencies;
current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, arbitration awards and settlements;
current license to practice the Member’s profession in any state, and whether such license or Montana Drug Enforcement Agency Administration registration, if applicable, is or ever has been, either voluntarily or involuntarily, suspended, modified, terminated, restricted, surrendered, or has ever been, or is currently being, challenged;
degree to which the Member has completed accurate, timely and legible medical records and charts;
voluntary or involuntary termination of medical staff appointment or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another hospital;
compliance with all qualifications and criteria outlined in the bylaws, policies and rules and regulations of the Medical Staff and Hospital;
regular participation in emergency call rotations, if applicable to the Member;
peer recommendations from at least three (3) peers concerning the clinical competence, behavior, ability to interact harmoniously with others and other relevant factors;
compliance with the Hospital’s Organizational Responsibility Program;
payment of Medical Staff dues, if any;
conformity with the Hospital’s Medical Staff Development Plan, if any; and
other reasonable indicators of continuing qualifications and relevant findings from the Hospital’s quality assessment activities.

Pursuant to applicable law and Joint Commission standards, the Board of Directors has the ultimate responsibility and authority with respect to making reappointments to the Medical Staff and granting of Clinical Privileges and the Board of Directors may also
consider, in addition to the foregoing factors and whether the Member satisfies the basic qualifications for reappointment, the applicant’s employment by or affiliation with competing organizations, the effect reappointment of the applicant would have on Hospital operations, administration, or financial position, including the cost of Hospital’s provision of specific services or procedures, effect on Hospital’s reputation, effect on Hospital’s competitive position, or any other factor other than the applicant’s competency and qualifications which the Board of Directors determines in its discretion may adversely affect the best interests of patient care or the operations of Hospital.

2.F.4. Department Chairperson Procedure/Findings

(a) No later than two (2) months prior to the end of the current appointment period, the Director of Medical Staff Services, after verification of the information contained in the application, as the CEO’s designee, shall send to the Chairperson of the Department a current list of all Members whose appointment period is to expire and who have Clinical Privileges in that Department. The Director of Medical Staff Services shall maintain such list and shall provide the Department Chairperson with such list, together with a description of the Clinical Privileges each holds, and copies of their applications for inspection and review by the Department Chairpersons.

(b) The applicable Department Chairperson shall use his/her best efforts to evaluate the application and the performance of the Member within no longer than fifteen (15) days after receipt of the list and applications and shall provide the Credentials Committee with a written report on a form prescribed by the Credentials Committee of his/her findings concerning the qualifications of each Member seeking reappointment who has Privileges within such Department based upon the factors described in Section 2.F.3, which are within the Chairperson’s knowledge or otherwise available to the Chairperson. In the absence or unavailability of the Department Chairperson, the Department Vice Chairperson shall perform such review or if such Vice-Chairperson is also unavailable or has a conflict, another Active Staff Member of the Department. Such report shall include an evaluation of the Member’s performance and qualifications for continued Privileges and shall include a description of the Member’s ability to work with others and participation in Department functions. Such report shall also include the Chairperson’s (or Vice Chairperson’s or other designee’s) evaluation of the Member’s ability to perform the essential functions of the Clinical Privileges requested. The Chairperson shall include in each written report, when applicable, the reasons for any changes recommended in staff category, Clinical Privileges, or for non-reappointment. In the event that a Department Chairperson finds that a change in Clinical Privileges or Medical Staff category from those requested is appropriate, he/she (or his/her designee) shall discuss such findings with the Member prior to submission of his/her report. The Chairperson of such Department concerned shall be available to the Credentials Committee to answer any questions that may be raised with respect to any such report.
2.F.5. Processing of Applications for Reappointment

After receiving the reports from the applicable Department Chairperson and any comments or information concerning the Member from any other Member, the same procedures and processes applicable to initial applications to the Medical Staff set forth in Sections 2.B.4, 2.B.5 and 2.B.7 through 2.B.9 shall be applicable and followed.

2.F.6. Meeting With Affected Member

If, during the processing of a Member’s reappointment application, it becomes apparent to the Credentials or Medical Executive Committee or its Chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or deny or reduce any requested Clinical Privileges, the Chairperson of the Credentials or Medical Executive Committee may (but shall not be obligated to) notify the Member of the general tenor of the possible recommendation and ask if the Member desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected Member shall be informed of the general nature of the committee’s concerns and any evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this Policy with respect to hearings shall apply. Minutes of the discussion in the meeting shall not be kept. However, the Credentials Committee shall indicate as part of its report to the Medical Executive Committee in the case of the Credentials Committee or the Medical Executive Committee in its report to the Board of Directors in the case of the Medical Executive Committee whether such a meeting occurred.

2.F.7. Requests for Modification of Appointment Privileges

A Medical Staff Member may, either in connection with reappointment or at any other time, request modification of his/her category of Medical Staff appointment or Department affiliation, by submitting a written application to the Director of Medical Staff Services on such form as may be prescribed by the Medical Executive Committee and the Board of Directors. Such Member shall have the burden for justifying such modification(s). Such application shall be processed in the same manner as applications for reappointment to the Medical Staff.

ARTICLE 3

ALLIED HEALTH PROFESSIONALS

3.A. QUALIFICATIONS FOR PRIVILEGES OR SCOPES OF PRACTICE

3.A.1. General

No healthcare provider (other than Physicians, Dentists, or Podiatrists whose rights and duties are described in Article 2) shall provide, or assist in the provision of, health care services to patients in the Hospital unless such person has been granted Clinical
Privileges or Scopes of Practice to do so by the Board of Directors, as specifically provided in this Article 3.

3.A.2. Must Be Granted Privileges or Scopes of Practice

All persons who may provide, or intend to provide, health care services to patients within the Hospital, including, Advanced Practice Registered Nurses, social workers, registered nurses, technologists, technicians, Medical Assistants, Physician Assistants and such other persons providing health care services who have been individually authorized by license or certification, or both, to provide such healthcare within the scope of his/her license or certification or who provide limited care under the direct supervision of Members of the Medical Staff and who the Board of Directors has determined may practice within the Hospital shall be subject to this Article, except (i) Physicians, Dentists and Podiatrists, and (ii) those employees of the Hospital (other than Advanced Practice Registered Nurses or Physician Assistants, if any, employed by the Hospital) who may be credentialed through other mechanisms at the Hospital.

Psychologists who practice within the hospital and are licensed to provide such care as specified by their scope of practice shall be under the general supervision of the members of Medical Staff.

3.A.3. Qualifications

Only those Allied Health Professionals who can document their required licensure or certification, experience, background, training, demonstrated ability and continuing competence, ability to perform the essential functions of the Clinical Privileges or Scopes of Practice sought, with or without accommodation, adherence to the ethics of their profession, ability to work harmoniously with others, document their agreement to conform with and adhere to the Ethical Religious Directives as referenced in Section 2.A.6., provide professional services deemed by the Board of Directors to be consistent with the mission of the Hospital and in the best interests of patient care as determined by the Board of Directors and for which services there is determined to be a need and who satisfy the other requirements of this Article shall be eligible to be granted Privileges to practice at the Hospital. No Allied Health Professional who has been excluded from Medicare, Medicaid or any other government sponsored health plan or who has been convicted of, plead guilty to a charge of, or entered a plea of no contest to a charge of, a felony which reasonably relates to the ability of the Allied Health Professional to exercise the Clinical Privileges or Scopes of Practice requested or granted to him/her, whether or not sentence has been imposed, shall be eligible to be granted Clinical Privileges or Scopes of Practice.

3.A.4. No Automatic Entitlement to Privileges or Scopes of Practice

No Allied Health Professional shall be entitled to be granted or to exercise any particular Clinical Privileges or Scopes of Practice in the Hospital merely by virtue of the fact that such Allied Health Professional:

(a) is licensed to practice a profession in the State of Montana or any other state;
(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, Clinical Privileges or Scopes of Practice at any hospital, including this Hospital;

(d) resides in the geographic service area of the Hospital as defined by the Board of Directors; or

(e) satisfies the threshold requirements or qualifications for granting of Clinical Privileges or Scopes of Practice in Section 3.A.3.

3.A.5. Board Has Ultimate Responsibility and Authority for Granting Privileges or Scopes of Practice

Pursuant to Montana law (including applicable regulations) and Joint Commission standards, the Board of Directors has the ultimate responsibility and authority with respect to granting of Clinical Privileges or Scopes of Practice to Allied Health Professionals and the Board of Directors may also consider, in addition to whether the Allied Health Professional satisfies the basic qualifications for granting of Clinical Privileges or Scopes of Practice, the Allied Health Professional’s employment by or affiliation with competing organizations, the effect granting of Clinical Privileges or Scopes of Practice to the Allied Health Professional would have on Hospital operations, administration, or financial position, including the cost of Hospital’s provision of specific services or procedures, effect on Hospital’s reputation, effect on Hospital’s competitive position, or any other factor in addition to the Allied Health Professional’s competence and qualifications which the Board of Directors determines in its discretion may adversely affect the best interests of patient care or the operations of Hospital.


No qualified Allied Health Professional shall be denied Clinical Privileges or Scopes of Practice on the basis of sex, race, disability, creed, religion, color, national origin, age, veteran or military status or other legally protected status. Reasonable accommodations will be made for the known disabilities of qualified Allied Health Professionals. Allied Health Professionals are expected to cooperate fully in the identification and selection of reasonable accommodations, focusing on the abilities of the Allied Health Professional and the health and safety of patients.

3.B. PROCEDURE FOR GRANTING PRIVILEGES OR SCOPES OF PRACTICE

3.B.1. Submission of Application

(a) Each individual who is subject to this Article seeking to practice as an Allied Health Professional shall submit an application to the Director of Medical Staff Services as the CEO’s designee on a form approved by the Board of Directors, upon which form the applicant shall demonstrate such individual’s qualifications, areas of practice and job description, Privileges or Scopes of Practice desired, and such other information as shall be requested. All requested information, including
the Allied Health Professional’s pledge to conform with and adhere to the Ethical Religious Directives referenced in Section 2.A.6., evidence of completion of Hospital’s HIPAA training, and supportive documentation shall be furnished before such application will be considered. Any application which continues to be incomplete sixty (60) days after the applicant has been notified of the failure to provide any information initially requested on the application form or of any additional information thereafter required shall be deemed to be withdrawn.

(b) The application of individuals seeking to provide services at the Hospital under the direct supervision of a Member of the Medical Staff, including but not limited to Medical Assistants and Physician Assistants, shall be accompanied by an acknowledgement in a form developed by the Hospital signed by the applicant’s employer who shall be a Member of the Medical Staff (and which, for such purpose, shall be deemed to include a medical group, corporation or other entity which includes Members of the Medical Staff) who shall verify that the individual is an employee of the Member of the Medical Staff (or such Member’s group), that such Member has the sole responsibility for such Allied Health Professional, that such individual is competent to perform the duties intended and the Privileges requested and will not act outside of such described duties and is covered by appropriate liability insurance satisfying the requirements of the Hospital. Employment of all Allied Health Professionals by a sponsoring Member (or the Member’s practice group) is a prerequisite to the granting (and continued exercise) of Clinical Privileges or Scopes of Practice except for such Allied Health Professionals who are permitted by their applicable licensure to practice independently without supervision by a Physician, Dentist or Podiatrist.

(c) The application of individuals seeking to provide services at the Hospital as Advanced Practice Registered Nurses shall be accompanied by a Collaborative Practice Agreement executed by a Member of the Medical Staff. The application of individuals seeking to provide services at Hospital as Physician Assistants shall be accompanied by a written Physician Assistant supervision agreement executed by a Member of the Medical Staff who will be supervising such Physician Assistant.

(d) Providing Verification of Identity.

At any time following submission of the Allied Health Professional’s completed application for Clinical Privileges or Scopes of Practice and prior to Board of Directors final action on such application, each Allied Health Professional shall provide verification of his/her identity by personally appearing before a representative of the Director of Medical Staff Services and presenting to such representative a government-issued photo identification so that such representative may personally verify the identity of the applicant. No application shall be finally approved until the Allied Health Professional has so personally appeared and provides such required verifying identification.

(a) The completed application shall be processed as follows:

(1) Applications submitted by all Allied Health Professionals shall be initially reviewed by the Director of Medical Staff Services who shall verify the information contained in the application. The application shall be presented to an allied health professional subcommittee of the Credentials Committee for review and recommendation. The application shall then be referred to the Chairperson of the applicable Department for review and evaluation. The Chairperson of the applicable Department shall prepare a written report on a form prescribed by the Credentials Committee concerning the applicant’s qualifications for the Clinical Privileges or Scopes of Practice requested.

(2) The Department Chairperson’s findings as to the qualifications of the applicant and appropriateness of the Clinical Privileges or Scopes of Practice requested, together with the application and the recommendations of the allied health professional subcommittee, shall then be transmitted to the Credentials Committee for its evaluation.

(3) The Credentials Committee shall consider the application and findings of the Department Chairperson and the allied health professional subcommittee as to the qualifications of the applicant and the appropriateness of the Privileges or Scopes of Practice being sought and in its review, if it determines it to be appropriate, may use the expertise of outside consultants or any Member or Allied Health Professional having Clinical Privileges or Scopes of Practice at the Hospital if additional information is needed regarding the Allied Health Professional’s application or the Credentials Committee may refer the application to an ad hoc committee comprised of appropriate health care professionals (which may include Allied Health Professionals) for its review and findings as to the requested Privileges or Scopes of Practice, the required training, education and experience and satisfaction thereof by the applicant. The Credentials Committee shall have the right to require the applicant and, in the case of Allied Health Professionals who will act only under the supervision of a Member of the Medical Staff, their supervising Medical Staff Member, to meet with the committee to discuss any aspects of the applicant’s application, qualifications, or Clinical Privileges or Scopes of Practice. Following the Credentials Committee’s review (including its consideration of the findings of the ad hoc committee, if any), the same procedures for evaluating applications to the Medical Staff set forth in Section 2.B shall be followed with respect to evaluation and approvals of the application of Allied Health Professionals for Clinical Privileges or Scopes of Practice, including submission of a health status questionnaire. Clinical Privileges or Scopes of Practice may be granted for up to twenty-four (24) months.
(4) The Board of Directors may consider the Medical Staff Development Plan, if applicable, and existing contractual arrangements (including employment relationships) concerning the Allied Health Professional’s area of practice in determining whether to grant Clinical Privileges or Scopes of Practice.

3.C. PROCEDURE FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

3.C.1. Temporary Clinical Privileges

Temporary Privileges shall not routinely be granted to Allied Health Professionals except in such extraordinary situations as the CEO, President of the Medical Staff and the Chairperson of the applicable Department in which such Privileges or Scopes of Practice are sought determine (1) are necessary to fulfill an important patient case, treatment or service need, (2) to avoid undue hardship to the Hospital or the Medical Staff, or (3) are otherwise in the best interests of the Hospital. The CEO or his/her designee may grant temporary Clinical Privileges or Scopes of Practice to an applicant for a specific time period not exceeding ninety (90) days, upon receipt of a completed application for Clinical Privileges or Scopes of Practice and after making inquiry to the National Practitioner Data Bank (and receipt of the response therefrom), if applicable, verifying information as to licensure or certification, if applicable, competence, character, ethical standing (including whether the Allied Health Professional has ever been excluded from the Medicare, Medicaid or other government sponsored healthcare programs) verifying professional liability insurance coverage, receipt of the acknowledgment from the Allied Health Professional’s employer who is a Medical Staff Member of employment and responsibility for the applicant if the Allied Health Professional is a Medical Assistant, Physician Assistant or other provider who shall not practice independently of Physician or Dentist supervision, as applicable, receipt of the favorable recommendation of the Chairperson of the applicable Department, and after consulting with the Chairperson of the Credentials Committee. In exercising such Privileges or Scopes of Practice, the applicant shall act under the supervision of his/her sponsoring Member of the Medical Staff or, if the Allied Health Professional may exercise Clinical Privileges or Scopes of Practice without direct Physician or Dentist supervision, the Chairperson of the Department applicable to the requested Privileges or Scopes of Practice. In all cases only applicants who have no current or previously successful challenge to licensure or registration, have no adverse criminal history, have not been subject to involuntary termination of Clinical Privileges or Scopes of Practice at another healthcare organization, have not been subject to involuntary limitation, reduction, denial, or loss of Clinical Privileges or Scopes of Practice, and have no unusual pattern of or excessive number of professional liability actions or claims, whether currently pending, having resulted in final judgments or arbitration awards against the applicant or settlements, shall be considered for the granting of temporary Privileges or Scopes of Practice.

3.C.2. Disaster Privileges or Scopes of Practice for Allied Health Professionals

(a) Appropriate temporary Privileges or Scopes of Practice may be granted by the CEO, President of the Medical Staff or any designee thereof to any Allied Health...
Professional who is not an applicant for Clinical Privileges or Scopes of Practice in the case of a disaster when the Hospital has activated its Emergency Management Plan and is unable to otherwise meet immediate patient needs, upon presentation thereto of a valid picture ID issued by a state, federal or regulatory agency (e.g., a driver’s license or passport), AND any of the following:

(1) a current picture hospital ID card that clearly identifies professional designation,

(2) a current license or certificate to practice the Allied Health Professional’s profession,

(3) primary source verification of the license,

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

(5) 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), or

(6) identification by current Hospital personnel or Medical Staff Member(s) who possess personal knowledge regarding the provider’s identity and ability to act as a licensed independent practitioner.

Any such Allied Health Professional granted disaster Privileges or Scopes of Practice shall have assigned thereto a Physician, Dentist or Podiatrist Member, as applicable, to directly observe the care provided by such Allied Health Professional receiving disaster Privileges or Scopes of Practice. When such disaster has ended and patient care may adequately be provided by Hospital’s providers, such disaster Privileges or Scopes of Practice shall expire.

(b) The CEO or his/her designee will make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours as to whether to continue the disaster Privileges or Scopes of Practice initially granted.

(c) Steps shall be taken to credential an Allied Health Professional, to a similar extent as for temporary Privileges or Scopes of Practice, as soon as the immediate situation is under control, or within 72 hours, whichever occurs first.

(d) All patient cases involving the Allied Health Professional will be reviewed retrospectively by a Member of the Medical Staff.
3.C.3. Special Requirements

Special requirements of supervision and reporting may be imposed by the Department Chairperson concerned on any Allied Health Professional granted temporary Clinical Privileges or Scopes of Practice. Temporary Privileges or Scopes of Practice shall be immediately terminated by the CEO or his/her designee upon notice of any failure by the Allied Health Professional to comply with such special conditions.

3.C.4. Termination of Temporary Clinical Privileges or Scopes of Practice

(a) The CEO, after receiving a recommendation from the President of the Medical Staff or the Chairperson of the Department responsible for the Allied Health Professional’s supervision, the President of the Medical Staff and the Chairperson of the applicable Department may at any time terminate temporary Privileges or Scopes of Practice.

(b) The granting of any temporary or disaster Clinical Privileges or Scopes of Practice is a courtesy on the part of the Hospital. The refusal to grant, the denial, termination or withdrawal of such Privileges or Scopes of Practice shall not entitle the Allied Health Professional to any of the procedural rights provided in this Policy.

(c) Temporary Privileges or Scopes of Practice shall be terminated automatically at any time the Executive Committee recommends, or the Board of Directors determines, not to grant Clinical Privileges or Scopes of Practice or at any time the application for Privileges or Scopes of Practice is withdrawn or deemed to be withdrawn. Similarly, at the Medical Executive Committee’s or Board of Directors’ discretion, temporary Clinical Privileges or Scopes of Practice shall be modified to conform to the recommendation of the Medical Executive Committee or decision of the Board that the applicant be granted Privileges or Scopes of Practice different from the temporary Privileges or Scopes of Practice.

3.D. CONDITIONS OF PRACTICE

3.D.1. Allied Health Professionals Generally:

(a) Allied Health Professionals, other than Medical Assistants, may, subject to any licensure requirement or other legal limitations and subject to the scope of the Privileges granted to them by the Board of Directors, as applicable, exercise clinical judgment within the areas of their professional competence and may participate directly in the medical management of patients within the scope of their Privileges and licensure pursuant to the written orders of a Physician, a Dentist, or Podiatrist as applicable. Audiologists and social workers may practice without a written order to the extent permitted by law and their licensure.

(b) Allied Health Professionals shall not have admitting Privileges or Scopes of Practice and shall practice at the discretion of the Board of Directors, subject to any rights granted to them in Article 5. Subject to the foregoing, the grant of all
initial Clinical Privileges or Scopes of Practice shall be provisional for a period of up to, but not exceeding, twenty-four (24) months (which period may be extended by the Board of Directors upon the recommendation of the Medical Executive Committee) from the date of the original grant of Clinical Privileges or Scopes of Practice.

(c) Upon approval by the Board of Directors, the Allied Health Professional shall be appointed a proctor within his/her discipline, if possible. The proctor will be responsible for the evaluation of the Allied Health Professional’s provisional monitoring requirements as set forth by their Department. The proctor will provide feedback to the Allied Health Professional during the evaluation and provide a written summary to the Allied Health Professional and the Chairperson of the Department at the completion of the evaluation. The evaluation will be completed within the first eighteen (18) months of privileges to allow adequate time for review and recommendations prior to the end of the twenty-four (24) month provisional period.

(d) During the term of this provisional grant, the Allied Health Professional shall be evaluated by the Chairperson of the Department in which the Allied Health Professional has Clinical Privileges or Scopes of Practice, and by the relevant committees of the Medical Staff and the Hospital as to clinical competence and by the Hospital and Medical Staff as to the Allied Health Professional’s general behavior and conduct in the Hospital.

(e) Provisional Clinical Privileges or Scopes of Practice shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted.

(f) Continued granting of Privileges or Scopes of Practice after the provisional period shall be conditioned on an evaluation of the Allied Health Professional’s demonstrated competency, behavior and competency and satisfaction of his/her responsibilities set forth in Section 3.E below. The applicable Department Chairperson, Medical Staff and Hospital committees and Department supervisors shall review the behavior, conduct and competence of the Allied Health Professional and submit their evaluation on forms prescribed by the Hospital. Non-employed Allied Health Professionals shall be evaluated upon the same criteria as comparable employees of the Hospital.

(g) Application for renewal of such Privileges or Scopes of Practice shall be submitted at least three (3) months prior to expiration of such initial grant period and shall be processed in the same manner as for initial grant as set forth in Section 3.B. Renewal Privileges or Scopes of Practice may be granted for periods not exceeding twenty-four (24) months, with annual competency evaluations except for advanced practice nurses and physician assistants.

(h) Allied Health Professionals may only engage in acts within the scope of practice or Clinical Privileges specifically granted by the Board of Directors.
(i) Allied Health Professionals may be assigned to one or more department(s) (but shall not have any vote therein) and may be assigned to and serve on Medical Staff and Department committees and on Hospital services.

3.D.2. Applicable to Medical Assistants, Physician Assistants and Nurses Only:

(a) Any activities permitted by the Board of Directors to be done at the Hospital by Medical Assistants, Physician Assistants or nurses (other than Advanced Practice Registered Nurses) if not employed by the Hospital, or by any other healthcare professionals who may practice only under the direct supervision of a Physician, Dentist, or Podiatrist shall be performed only under the direct and immediate supervision of that individual’s employer who shall be at all times a Member of the Medical Staff. (For these purposes if a corporation, partnership or other entity is the employer, the requirement that such Medical Assistant’s, Physician Assistant’s or nurse’s employer be a Member shall be deemed satisfied if such entity has Physician, Dentist, or Podiatrist employees, partners or members who are Members of the Medical Staff and one of such Members shall be the supervising Physician, Dentist, or Podiatrist of such Medical Assistant, Physician Assistant or nurse). However, “direct and immediate supervision” shall not require the actual physical presence of the Member, unless required by state regulations or the nature of the Allied Health Professional’s licensure, activities or Privileges. Should any Medical Staff Member or Hospital employee have any question regarding the clinical competence or authority of the Medical Assistant, Physician Assistant or nurse either to act or to issue instructions outside the physical presence of the Member in a particular instance, such Member or Hospital employee has the right to require that the Medical Assistant’s, Physician Assistant’s or nurse’s supervising Member validate, either at the time or by a later specified time, the instructions of the Medical Assistant, Physician Assistant or nurse. Any act or instruction of the Medical Assistant or Physician Assistant shall be delayed until such time as the Member or Hospital employee is reasonably assured that the act is clearly within the scope of the Medical Assistant’s, Physician Assistant’s or nurse’s activities as permitted by the Board of Directors. At all times the employing or supervising Medical Staff Member will remain responsible for all acts of the Medical Assistant, Physician Assistant or nurse while at the Hospital.

(b) The number of Medical Assistants, Physician Assistants and nurses acting as employees of one Medical Staff Member, as well as the scope of the activities they may undertake, shall be consistent with the applicable state statutes and regulations, Joint Commission standards, the rules and regulations of the Medical Staff and the policies of the Board.

(c) It shall be the responsibility of the Medical Staff Member employing the Medical Assistant, Physician Assistant or nurse to provide professional liability insurance for the assistant in amounts required by the Board of Directors that covers any activities of the Medical Assistant, Physician Assistant or nurse at the Hospital,
and to furnish evidence of such to the Hospital. The Medical Assistant, Physician Assistant or nurse shall act at the Hospital only while such coverage is in effect.

(d) Medical Assistants, Physician Assistants and nurses or other healthcare professionals who may practice only under the direct supervision of a physician, Dentist or Podiatrist may act at the Hospital pursuant to their approved delineation of Privileges or Scopes of Practice only so long as he or she remains an employee of and is directly supervised by the sponsoring Medical Staff Member who has been granted appropriate Privileges by the Board of Directors. Termination of employment by the sponsoring Member (or Member’s group, as applicable) or termination or suspension of the sponsoring Member’s Clinical Privileges or Scopes of Practice may result in suspension of Clinical Privileges, and may result in loss of Clinical Privileges or Scopes of Practice, as provided in Section 4.C.

3.E. RESPONSIBILITIES

As a condition to the granting of Clinical Privileges or Scopes of Practice, each Allied Health Professional shall be deemed to have agreed, by his/her submission of an application for Privileges or Scopes of Practice, to:

1. provide his or her patients with quality and efficient care consistent with the generally recognized professional standards of his or her specialty and at all times retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Hospital for whom he or she is providing services, or arrange for an appropriate qualified alternate for such care and supervision;

2. be subject to and abide by the policies and rules of the Hospital and the Medical Staff applicable to his or her practice and Privileges or Scopes of Practice and with all other lawful standards;

3. discharge all Department, committee and Hospital functions for which he or she is responsible by appointment, election or otherwise, including attendance at such meetings;

4. if permitted by law to do so, write orders only to the extent established for him or her by any Hospital or Medical Staff Rules and Regulations or procedure but not beyond the scope of his or her license, certificate or other credentials;

5. prepare and complete in a timely, legible and accurate manner the medical and other required records with respect to the treatment or care provided by such Allied Health Professional in accordance with the Medical Staff Rules and Regulations for all patients to whom he or she provides care in the Hospital;

6. abide by the ethical principles of the Allied Health Professional’s profession;

7. participate, as appropriate, in the patient care monitoring and other quality improvement activities required by the Medical Staff, in supervising provisional
grantees appointees of his or her same profession, and in the discharge of such other functions as may from time to time be required;

8. maintain and provide at least annually verification of licensure or certification, if applicable, and evidence of current, valid professional liability insurance coverage having such limits and coverage as are satisfactory to the Board of Directors;

9. work cooperatively with Medical Staff Members, other Allied Health Professionals, nurses, Hospital administration and other Hospital personnel so as not to adversely affect patient care or Hospital administration;

10. provide to the Director of Medical Staff Services and the CEO, with or without request, new or updated information, as it occurs, that is pertinent to any question on the application form, whether before granting of appointment or thereafter, including but not limited to providing updated or additional information concerning (i) the filing of or significant change in any professional liability action against the Allied Health Professional; (ii) the filing of any complaint with, or the commencement of any disciplinary action, investigation or proceeding by the applicable state licensing board of any state in which the Allied Health Provisional is licensed or certified concerning the Allied Health Professional’s professional conduct or competency, license or registration; (iii) the filing of any complaint with, or the commencement of an investigation, proceeding or disciplinary action by the federal or state government or any agency or department thereof concerning the Allied Health Professional’s professional conduct, billing practices, or competence; (iv) the filing of any complaint with, or the commencement of any investigation or proceeding which may affect the applicant’s Clinical Privileges at any other hospital or professional association or society; (v) receipt of notice of any change in status of the Allied Health Professional’s professional liability insurance or coverage, including cancellation, non-renewal, reduction or restriction in coverage or imposition of any conditions on the Allied Health Professional’s practice or coverage with respect thereto; (vi) conviction of, pleading guilty to a charge of, or entering a no contest plea to a charge of, any criminal offense (including driving under the influence but excluding minor traffic violations) whether or not sentence was imposed, suspended or probation granted, which criminal offenses reasonably could relate to the ability of the Allied Health Professional to exercise the Clinical Privileges or Scopes of Practice sought; (vii) notification of the loss of his/her DEA number, if applicable, or exclusion or debarment from the Medicaid, Medicare or other government sponsored healthcare benefit program, is under investigation by Medicaid or Medicare, or has been subjected to any fine, penalty or sanction by Medicare or Medicaid; (viii) the voluntarily relinquishment, agreement not to exercise, or involuntary loss of any licensure, certification, registration, Clinical Privileges or Scopes of Practice at any healthcare facility; (ix) entering into an agreement with any impaired provider or similar committee as a result of any substance abuse or other disease or disorder; or (x) development of any mental or physical illness or having sustained any injury which could have an effect on the exercise of the individual’s Clinical Privileges or Scopes of Practice.
11. agree that any significant misrepresentation or misstatement determined by the Director of Medical Staff Services, after consulting with the Chairperson of the Credentials Committee, to exist in, or omission from, the application, whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of Clinical Privileges or Scopes of Practice. In the event of such misrepresentation, Hospital may decline to process such application as an incomplete application and such application shall be deemed withdrawn. In the event that Clinical Privileges or Scopes of Practice have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery shall be grounds for and may result in immediate suspension or termination of Clinical Privileges or Scopes of Practice;

12. maintain the confidentiality of Hospital’s strategic plans, budgets, financial information or other proprietary or confidential information which the Allied Health Professional may be provided or otherwise acquire by virtue of service on Medical Staff or Hospital committees or participation in Medical Staff functions, activities or otherwise;

13. conduct his/her activities in conformity with Hospital’s Organizational Responsibility Program;

14. authorize the release of all information necessary for an evaluation of the Allied Health Professional’s qualifications for initial or continued Clinical Privileges or Scopes of Practice;

15. agree to submit accurate responses to Hospital’s health status questionnaire to the Quality and Patient Safety Committee of the, if Privileges are conditionally recommended;

16. comply with the Hospital’s HIPAA compliance policies;

17. cooperate with Medical Staff committees and investigating panels or subcommittees in any review or investigation of the Allied Health Professional’s patient care, competence, conduct or ability to practice without posing a danger to Members of the Medical Staff, other providers or patients;

18. agree that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken at the Hospital;

19. agree that the failure of an Allied Health Professional to provide the notification as required by (10) above shall be grounds for summary suspension or other action related to the Allied Health Professional’s Privileges or Scopes of Practice,

20. acknowledge that the failure to provide complete and accurate information in connection with any investigation concerning the Allied Health Professional’s Clinical Privileges or Scopes of Practice shall be grounds for immediate termination Clinical Privileges or Scopes of Practice,
21. agree not to sue the Hospital, its current or former employees, current or former Medical Staff members, or anyone acting by or for the Hospital and the Medical Staff for any matter relating to the application for Clinical Privileges or Scopes of Practice, the collection of information regarding the applicant, the evaluation of the applicant’s qualifications, processing of his/her application or any matter related to Clinical Privileges or Scopes of Practice; and

22. extend absolute immunity to the Hospital, its current or former employees, current and former Medical Staff Members and all individuals acting by or for the Hospital and/or the Medical Staff for all matters relating to granting of Clinical Privileges or Scopes of Practice or the applicant’s qualifications for the same.

3.F. BURDEN OF PROVIDING INFORMATION

1. The applicant shall have the burden of producing information deemed adequate by the Medical Staff and the Board of Directors for a proper evaluation of his/her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications, including specifically information from other hospitals, and information concerning malpractice actions and disciplinary or competency investigations or actions, as the Medical Staff or any committee thereof or committee of any applicable Department may request in order to provide appropriate quality assessment.

2. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

3. Until the applicant has provided all information requested by the Board of Directors, the application for Clinical Privileges or Scopes of Practice will be deemed incomplete and will not be processed, except for such limited review or processing as may specifically be provided in this Policy or as the Director of Medical Staff Services or Medical Staff or its designees may elect in their sole discretion. Should information provided in the initial application form change during the course of the appointment term, the applicant has the burden to provide as soon as reasonably possible to the Director of Medical Staff Services and Credentials Committee sufficient information about such change for the Credentials Committee to review and assess such change.

3.G. EMPLOYEES OF HOSPITAL

For the purposes of this Policy and the procedures for granting Clinical Privileges pursuant to this Article 3, individuals who are employees of the Hospital, other than Advanced Practice Registered Nurses and Physician Assistants, who would otherwise be considered under this Policy to be Allied Health Professionals, while working as employees of the Hospital shall not be subject to the provisions of this Policy, but shall be governed by the Hospital’s policies, employee manuals and procedures and job descriptions as may be established and by the condition of or terms of their employment. Individuals performing services at the Hospital as Allied Health Professionals while not
working as employees of the Hospital shall be subject to the procedures of this Article and this Policy.

ARTICLE 4

ACTIONS AFFECTING MEDICAL STAFF MEMBERS OR ALLIED HEALTH PROFESSIONALS

4.A. PROCEDURES FOR ADDRESSING QUESTIONS INVOLVING MEDICAL STAFF MEMBERS’ OR ALLIED HEALTH PROFESSIONALS’ ACTIONS.

4.A.1. Initiation of Action

Whenever, on the basis of information and belief, any Member of the Medical Staff, any Allied Health Professional, any employee of the Hospital or any member of the Board of Directors has cause to question the actions of a Medical Staff Member or an Allied Health Professional involving any of the grounds described in Section 4.A.2 hereof, such person shall submit a written report to the Hospital’s Vice President/Chief Operating Officer or his/her designee identifying the Medical Staff Member or Allied Health Professional involved and describing the specific incident, activity or conduct which gave rise to it. Further, if the matter involves a potential violation of the Organizational Responsibility Program, the Hospital’s Corporate Compliance Officer shall be notified and the Corporate Compliance Officer may conduct an investigation independent of or in connection with any investigation under this Article 4. Upon receipt of such report the Hospital’s Vice President/Chief Operating Officer shall transmit such report to the President of the Medical Staff (unless the subject of the complaint and in such event to the President-Elect) and the CEO. The President of the Medical Staff and CMO may also initiate a review on his or her own.

4.A.2. Grounds for Action

The following shall be grounds for initiating a report questioning the conduct or activity of a Member or an Allied Health Professional:

(a) questions regarding the clinical competence of any Member or Allied Health Professional;

(b) questions regarding the care or treatment of a patient or patients or management of a case by any Member or Allied Health Professional;

(c) the known or suspected violation by any Member or Allied Health Professional of applicable ethical standards or the bylaws, policies, rules or regulations of the Hospital or the Board of Directors or the Medical Staff, including, but not limited to the Hospital’s quality assessment, risk management, and utilization review programs and Organizational Responsibility Plan or involves conduct which is prohibited under any local, state or federal law or regulation;
(d) behavior or conduct on the part of any Member or Allied Health Professional that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or the Medical Staff, including the inability of the Member or Allied Health Professional to work harmoniously with other Members, Allied Health Professionals, nurses and technical personnel, Hospital employees or Hospital administration;

(e) the existence of any significant misstatements in or omissions from the Member’s application for appointment or reappointment to the Medical Staff or matters submitted in connection therewith;

(f) the existence of any significant misstatements in or omissions from the Allied Health Professional’s application for Clinical Privileges or Scopes of Practice or matters submitted in connection therewith;

(g) an act by a Member or Allied Health Professional that is or may be below the applicable standard of care and which has a reasonable probability of causing injury to a patient or which may be grounds for disciplinary action by the Practitioner’s or Allied Health Professional’s state licensing agency;

(h) questions involving the revocation, termination, suspension or restriction of licensing, federal or state drug registration, professional liability insurance, medical staff appointment or Clinical Privileges or Scopes of Practice at another hospital or continuing medical education requirements;

(i) questions involving any disciplinary action against a Member or Allied Health Professional by another hospital or entity;

(j) a conviction, indictment or investigation by federal or state authorities concerning suspected Medicare, Medicaid or other government sponsored healthcare plan or insurance fraud, including any violation of federal or state anti-kickback laws or false claims acts;

(k) a conviction or indictment for, or investigation into, suspected drug law or sexual predator law violations;

(l) a Member who is required to have his/her procedures monitored:

1. performs one or more procedures without the required monitoring,

2. undertakes a procedure notwithstanding the specific, written decision to the contrary by a monitor, or

3. during the course of a procedure, refuses to comply with the monitor’s instructions and/or transfer control of the care of the patient to the monitor upon a specific demand to that effect made by the monitor;
(m) litigation or arbitrary proceedings, including testimony (deposition, hearing or trial) given by a Member or Allied Health Professional as an expert witness or otherwise, which may call into question a Member’s or Allied Health Professional’s qualifications, competency, medical or professional judgment, conduct or ability to practice; or

(n) violation of the Ethical Religious Directives referenced in Section 2.A.6.

4.A.3. Preliminary Review by the President of the Medical Staff

(a) Upon receipt of a statement or report pursuant to Section 4.A.1, or upon receipt of a complaint or other notice from a patient or family member of a patient concerning any matter described in Section 4.A.2, the President of the Medical Staff (or President-Elect if the President of the Medical Staff is the subject of the report) or his/her designee shall promptly notify the applicable Department Chairperson in writing of all such reports and request for investigation and shall keep the Chairperson of the applicable Department and the President of the Medical Staff fully informed of all action taken in connection therewith. The President of the Medical Staff or his/her designee shall preliminarily review the matter and shall interview appropriate Members of the Medical Staff, Allied Health Professionals, Hospital personnel as the President of the Medical Staff deems necessary or appropriate, including the Member or Allied Health Professional being investigated.

(b) In the event the complaint involves a potential violation of the Hospital’s Organizational Responsibility Plan, the President of the Medical Staff shall notify the Hospital’s Corporate Compliance Officer, if not previously notified, and coordinate, as appropriate, the President of the Medical Staff’s investigation with the Corporate Compliance Officer.

(c) The President of the Medical Staff may utilize the expertise of one or more Members of the Medical Staff or others (including the Hospital’s counsel) to advise him/her as to specific patient care issues or other matters as to which the President of the Medical Staff may deem helpful to his/her review and initial evaluation.

(d) In the event the Member or Allied Health Professional involved is also an employee of the Hospital, the President of the Medical Staff (or his/her designee) shall also consult with and coordinate, as applicable, with the human resources department of the Hospital.

(e) In the event the President of the Medical Staff or his/her designee, as applicable, is able to resolve the matter or determines that there is no basis for action against the Member or Allied Health Professional, the President of the Medical Staff or his/her designee, as applicable, shall nevertheless notify the Chairperson of the applicable Department and, if appropriate and CEO by written report of his/her findings, conclusions and action taken. However, in the event the President of the
Medical Staff or his/her designee determines that he/she is unable to resolve the matter, or is unable to determine that there is no substance to the complaint or basis for either the allegation or for taking action against such Member or Allied Health Professional, after consultation with the CEO, except as hereafter provided, the President of the Medical Staff or his/her designee, as applicable, shall promptly refer the matter to the Medical Executive Committee. In the event that the complaint or matter is so referred by the President of the Medical Staff, he/she shall notify the Member or Allied Health Professional that a complaint has been received and referred to the Medical Executive Committee for investigation.

4.A.4. Initial Action by the Medical Executive Committee

(a) Upon receipt of a report from the President of the Medical Staff or his/her designee, as applicable, that he/she has been unable to resolve the complaint or has not been able to determine that there is no basis for action against the Member or Allied Health Professional and that an investigation should be undertaken, the Medical Executive Committee shall promptly initiate an investigation of the complaint. Further, if the CEO or his/her designee disagree with the conclusion of the President of the Medical Staff (or his/her designee, if applicable) that no basis existed either for the allegation or for taking action against the Member or Allied Health Professional, he/she may request that investigation be undertaken by submitting the President of the Medical Staff’s report and his/her request to the Chairman of the Executive Committee who shall promptly initiate an investigation of the complaint.

(b) Upon receiving the President of the Medical Staff’s report or request from the President of the Medical Staff, or the CEO for any investigation, the Chairperson of the Medical Executive Committee may immediately appoint an ad hoc committee to investigate the matter if the Chairperson of the Medical Executive Committee believes that the matter requires immediate investigation. The ad hoc committee shall consist of no fewer than three (3) persons who may or may not be Members of the Medical Staff. The committee should include one (or more as appropriate) members who are not Members of the Medical Staff when expertise in a specialty is not readily available from Members of the Medical Staff or when unrelated or unbiased Members or Allied Health Professionals, as appropriate, who would not be direct competitors of the Member or Allied Health Professional in question are not readily available as the Chairperson of the Medical Executive Committee shall reasonably determine. Care shall be taken in selecting members of such committee who do not have a bias against the Member or Allied Health Professional in question or who are in direct economic competition with the Member or Allied Health Professional in question. The committee shall not include partners, associates or relatives of the Member being investigated. Committee appointees will be promptly notified. If practical, the President of the Medical Staff shall direct and coordinate the investigation.
The Chairperson of the Executive Committee shall report the appointment of the ad hoc investigating committee as soon as reasonably practical to the Medical Executive Committee.

In the event the Chairperson of the Medical Executive Committee elects not to so appoint an ad hoc investigating committee, the Executive Committee shall meet as soon as reasonably practical but not later than forty-five (45) days after receipt of the report from the President of the Medical Staff or his/her designee and his/her request for an investigation (or after receipt of a request for an investigation by the President of the Medical Staff, or the CEO if any of them disagrees with the conclusion of the President of the Medical Staff (or his/her designee, if applicable) that no basis existed either for the allegation or for taking action against the Member or the Allied Health Professional). After reviewing the report or request, the Medical Executive Committee shall appoint an ad hoc investigating committee in the manner described above to investigate the matter.

4.A.5. Investigative Procedure by the Ad Hoc Committee

(a) The ad hoc committee, if appointed, shall meet as soon as reasonably practicable, but not later than thirty (30) days after appointment. After evaluating the request for an investigation, if the ad hoc committee determines that:

(1) there is no basis for either the allegation or taking action against the Member or Allied Health Professional, the committee may, at its discretion, make a recommendation that no action is justified. The committee may make this recommendation with or without a personal interview with the Member or Allied Health Professional being investigated; or

(2) the request for an investigation contained sufficient information to warrant a full investigation, or that it cannot determine that there is no basis for the request, the committee shall immediately investigate the matter. If the committee determines after initial review that investigation is warranted, the Chairperson of the committee shall so advise the Chairperson of the Executive Committee who shall advise the Member or Allied Health Professional that the matter has been referred to the committee for investigation.

(b) The Member or Allied Health Professional under investigation shall have an opportunity to meet with the investigating committee before such body makes its report of its investigation and conclusions to the Medical Executive Committee. At this meeting (but not, as a matter of right, in advance of it) the Member or Allied Health Professional shall be informed of the general nature of the evidence supporting the matter being investigated and shall be invited to discuss, explain, or refute such evidence. This interview shall be administrative in nature and shall not constitute a hearing, and none of the procedural rules provided in this Policy
with respect to hearings shall apply. Since such meeting is not a hearing in accordance with the hearing procedures of this Policy, the Member or Allied Health Professional under investigation shall not be permitted to have an attorney or other representative present. Refusal to attend such meeting by the Member or Allied Health Professional under investigation or his/her refusal to provide information or records requested by the committee shall be duly noted by the committee. The committee will proceed with the investigation which may lead to appointment of the Member and/or Clinical Privileges of the Member or Allied Health Professional be revoked, suspended or terminated. A summary of such interview, if held, shall be made by the committee and be included with its report to the Medical Executive Committee.

(c) The ad hoc committee shall have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed to advise the committee on any specific matter. If the committee believes that the physical or mental condition or abilities of the Member or Allied Health Professional are in issue, such committee may also require a physical and/or mental examination of the Member or Allied Health Professional being investigated by a Physician or Physicians satisfactory to such body and shall require that the report of such examination as to (i) the ability of the Member or Allied Health Professional to perform the essential functions of the Clinical Privileges which the Member or Allied Health Professional has been granted without imposing a direct threat to the health or safety of the Member or Allied Health Professional, patients or others and whether there is any need for accommodation to enable the Member or Allied Health Professional to perform such Clinical Privileges, or (ii) that the Member or Allied Health Professional has demonstrated emotional or psychological traits which adversely impact the Member’s or Allied Health Professional’s ability to work harmoniously with others, shall be made available to the committee for its consideration. Refusal to submit to such examination if requested by the committee shall be duly noted by the committee and may result in a recommendation by the committee that the Medical Staff appointment of the Member and/or Clinical Privileges of the Member or Allied Health Professional under investigation be revoked, suspended or terminated.

(d) If the matter under investigation involves a violation of the Organizational Responsibility Program, the ad hoc committee shall work with and coordinate the investigation with the Hospital’s Corporate Compliance Officer in any investigation conducted by the Corporate Compliance Officer.

(e) The ad hoc committee shall forward its findings and recommendations to the Medical Executive Committee for action pursuant to Section 4.A.8.

4.A.6. Precautionary Suspension of Privileges During Review

(a) If at any time during the investigation, the ad hoc committee believes that for the protection of patients of the Hospital, the orderly operation of the Hospital or
otherwise for the protection of the Hospital, the Clinical Privileges of the Member or Allied Health Professional under investigation should be suspended or restricted in whole or in part, the committee shall notify the President of the Medical Staff (or if the subject of the investigation is the President, the CEO) and the CEO who may each, based upon the report of such committee, immediately suspend or restrict all or any part of the Member’s or Allied Health Professional’s Clinical Privileges as provided in Section 4.B or refer the matter to the Medical Executive Committee for evaluation and action. In lieu of such suspension the President of the Medical Staff (or CEO, as applicable) may meet with the affected Member or Allied Health Professional and ask such member or Allied Health Professional to voluntarily refrain from exercising all or certain Clinical privileges while such investigation is pending. In the event of a suspension, the person imposing such suspension shall immediately notify the other of the CEO or President of the Medical Staff, and also the Chairperson of the Board of Directors, the Medical Executive Committee and the applicable Department Chairperson.

(b) In the event that the President of the Medical Staff or CEO elects to refer the matter to the Medical Executive Committee for evaluation and action as to the possible imposition of a precautionary suspension, the Medical Executive Committee shall meet as soon as reasonably practical to consider such recommendation and may, if it finds it warranted for the protection of patients of the Hospital, the orderly operation of the Hospital, or otherwise for the protection of the Hospital, suspend, in whole or in part, the Clinical Privileges of the Member or Allied Health Professional under investigation while investigation of whether to take a professional review action is being completed.

(c) Any such suspension or restriction shall be deemed to be precautionary in nature, for the protection of the Hospital’s patients, the orderly operation of the Hospital or otherwise for the protection of the Hospital. The suspension shall remain in effect, without appeal, during the investigation only, and shall not indicate the validity of the charges. Notification of imposition of such suspension shall be made by telephone or in person with the Member or Allied Health Professional by the President of the Medical Staff (or their designee) as soon after imposition as practical. Written confirmation of such suspension shall thereafter be promptly sent to the Member or Allied Health Professional. If such a precautionary suspension is placed into effect, such suspension shall be in effect while an investigation to determine whether a professional review action is needed but shall automatically cease and be of no further force or effect at the end of the 15th day following imposition unless sooner terminated or lifted as provided in this Policy or unless extended as provided in this Policy. The investigation shall be completed within fourteen (14) days of the suspension or reasons for the delay shall be transmitted to the Medical Executive Committee and CEO so that it may consider whether the suspension should be continued. Unless the Medical Executive Committee acts to continue such suspension or one of the persons or bodies authorized to summarily suspend the Clinical Privileges of a Member or Allied Health Professional pursuant to Section 4.B takes such action to suspend the Privileges of the Member or Allied Health professional for the reasons set
forth in Section 4.B, the suspension shall automatically terminate on the fifteenth (15th) day after initial imposition; provided, however, nothing herein shall prohibit such suspension from thereafter being reimposed by any person or body authorized by this Policy to do so for the reasons set forth in this Policy. If the suspension is continued by action of the Board of Directors, the suspended Member or Allied Health Professional shall have the procedural rights set forth in Article 5. For purposes of calculating the applicable deadlines under Article 5, the first day of such continuation is considered to be the first day of such suspension.

(d) In the event of imposition of a precautionary suspension of Privileges, the appropriate Department Chairperson, or if unavailable or the subject of such investigation, the President of the Medical Staff (or President-Elect if the President is the subject of the investigation), shall immediately assign to another Medical Staff Member or Allied Health Professional, as appropriate, with appropriate Clinical Privileges responsibility for the care of the patients of the suspended Member or Allied Health Professional until the precautionary suspension has been lifted or such patients are discharged from the Hospital. Where feasible, consideration should be given to the patient’s wishes in the selection of a substitute Member or Allied Health Professional.

4.A.7. Interviews During Suspension

When a Practitioner or Allied Health Professional has had his/her Privileges suspended pursuant to Section 4.A.6 or 4.B.1, the Practitioner shall be afforded an interview with the Medical Executive Committee if so requested. The interview shall not constitute a hearing, shall be informal and preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings under this Fair Hearing Plan. The Practitioner or Allied Health Professional shall be informed of the general nature of the adverse action and may present information relevant thereto. Such Practitioner or Allied Health Professional may request such an interview by delivering a written request either in person or by certified or registered mail to the President of the Medical Staff or, if such request was prompted by action of the Board of Directors, to the CEO, within ten (10) days following the date of his/her receipt of the notice of such suspension, and such interview shall then be held within ten (10) days of the receipt of such request. If an interview is requested, the time period for requesting a hearing, as set forth in Section 5.B.2, shall commence to run from the date of such interview. A record of the interview shall be kept but shall not be admissible as evidence in any subsequent hearing provided under Article 5.

4.A.8. Procedure Upon Completion of Investigation

(a) Upon completion of its investigation, or, if appropriate, at any time during its investigation, the ad hoc committee may do one or more of the following:

(1) Recommend that no action is justified;
Recommend that a requirement of consultation be imposed in the case of a Member or Allied Health Professional under investigation;

Recommend that a written warning or letter of reprimand be issued;

Recommend medical treatment or therapy;

Recommend that terms of probation be imposed;

Recommend a reduction or restriction on Privileges, in whole or in part;

Recommend suspension of Clinical Privileges for a specific term, including immediate suspension and for such purpose may refer such recommendation directly to the President of the Medical Staff pursuant to Section 4.A.6(a);

Recommend revocation of Medical Staff appointment in the case of a Practitioner under investigation and Clinical Privileges in the case of an Allied Health Professional under investigation;

Refer the matter to the Montana Professional Assistance Program or similar program; or

Make such other recommendations as it deems necessary or appropriate.

(b) The Chairperson of the ad hoc committee shall submit to the Executive Committee a written report, subject to any confidentiality requirements of such committee, setting forth the committee’s findings, conclusions and recommendations. The committee shall be available to the Medical Executive Committee to answer any questions that may be raised with respect to its recommendation(s).

4.A.9. Medical Executive Committee Action on Ad Hoc Committee’s Report

(a) The Medical Executive Committee shall meet as quickly as practical after receipt of the ad hoc committee’s report (but in no event later than thirty (30) days) to consider the recommendations of the ad hoc committee. The Medical Executive Committee may meet with the members of the ad hoc committee or request specific information or findings therefrom and upon conclusion of its evaluation of such report and information available to it may adopt or reject, in whole or in part, or modify such recommendations, or adopt a recommendation of its own, and based upon its conclusions impose or take such action as recommended or impose or take any other action which it is empowered to take as provided in this Policy, including but not limited to those actions described in Section 4.A.8(a).

(b) If the Medical Executive Committee’s recommendation or action would entitle the Member or Allied Health Professional being investigated to request a hearing and appeal of such action or recommendation and to the procedural rights
provided in this Policy, such recommendation shall be forwarded to the CEO who shall promptly notify the affected Member or Allied Health Professional by Special Notice. The CEO shall then hold the recommendation (except an immediate suspension) until after the Member or Allied Health Professional has been deemed to have waived the right to a hearing or until after the Member or Allied Health Professional has exercised such right and the process has been completed.

(c) If the action of the Medical Executive Committee would not entitle the Member or Allied Health Professional to a hearing, the action shall take effect immediately without action of the Board of Directors (unless the Medical Executive Committee has recommended action be taken by the Board of Directors) and without the right of appeal as provided in this Policy. A report of the action taken and reasons therefor shall be made to the CEO.

4.A.10. Board of Directors’ Action

(a) If the action of the Medical Executive Committee is to recommend action be taken by the Board of Directors and such recommendation either does not entitle the Member or Allied Health Professional to a hearing and the procedural rights set forth in Article 5 or such procedural rights have been waived by the Member or Allied Health Professional or have been concluded, the Board of Directors shall consider the recommendation of the Medical Executive Committee at its next regular meeting.

(b) In the event the Board of Directors initially determines to consider modification of the action of the Medical Executive Committee or takes action upon a recommendation of the committee that had not previously entitled the Member of Allied Health Professional to a hearing and the procedural rights set forth in Article 5 and such modification or action would entitle the Member or Allied Health Professional to a hearing in accordance with this Policy, it shall so notify the affected Member or Allied Health Professional, through the CEO, by Special Notice and shall take no final action thereon (except for a precautionary suspension of the Member or Allied Health Professional as provided in this Policy) until the Member or Allied Health Professional has had an opportunity to exercise the right to a hearing and appeal as provided in this Policy and such process has been completed.

4.B. PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

4.B.1. Grounds for Precautionary Suspension

(a) In lieu of the procedure set forth in Section 4.A (other than Section 4.A.6), the President of the Medical Staff or his/her designee, the Chairperson of the applicable Department, the Medical Executive Committee, the CEO or designee, or the President of the Board of Directors each shall have the authority to suspend all or any portion of the Clinical Privileges of a Member or Allied Health
Professional whenever such action is reasonably believed to be in the best interests of patient safety or care, the orderly administration of the Hospital or patient care, protection of the Hospital, or as authorized in any Medical Staff policy, including but not limited to the Disruptive Behavior and the Medical Staff Policy. Such suspension shall not imply any final finding of responsibility for the situation that prompted the suspension. Without limiting the foregoing but as an illustration, the following are examples of grounds for imposition of a suspension:

(1) the conduct of the Practitioner or Allied Health Professional creates a reasonable possibility of injury or damage to any patient, employee or person present in the Hospital or to the Hospital,

(2) the Practitioner or Allied Health Professional is charged with the commission of a felony,

(3) the Practitioner or Allied Health Professional is charged with the commission of a misdemeanor which may relate to the Practitioner’s suitability for Medical Staff appointment or the Allied Health Professional’s Clinical Privileges,

(4) the Practitioner or Allied Health Professional engages in or is charged with unlawful or unethical activity related to the practice of medicine or his/her professional,

(5) the Practitioner or Allied Health Professional engages in any dishonest, unprofessional, abusive or inappropriate conduct which is or may be disruptive of Hospital operations and procedures,

(6) the Practitioner or Allied Health Professional has had any medical staff appointment, Clinical Privileges, certification, licensure DEA Certificate or registration terminated, suspended, restricted, limited, reduced or modified in any way, has resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff membership or Clinical Privileges, or has voluntarily surrendered or agreed not to exercise any Clinical Privileges while under investigation or to avoid an investigation,

(7) it is determined that the Practitioner or Allied Health Professional made a material misstatement or omission on any pre-application or application for appointment or reappointment, or at any time provided incorrect information or otherwise deceived or attempted to deceive or mislead the Medical Staff and/or the Hospital,

(8) the Practitioner or Allied Health Professional has falsified or inappropriately destroyed or altered any medical record,

(9) the Practitioner or Allied Health Professional refuses to submit to evaluation or testing relating to the Practitioner’s or Allied Health
Professional’s mental or physical status, including refusal to submit to any testing related to drug or alcohol use,

(10) the Practitioner or Allied Health Professional abandons a patient or wrongfully fails or refuses to provide care to a patient,

(11) the Practitioner or Allied Health Professional engages in clinical activities outside the scope of the Practitioner’s or Allied Health Professional’s approved Clinical Privileges except as permitted in this Policy in the case of an emergency, or

(12) a Member who is required to have his/her procedures monitored:
   (i) performs one or more procedures without the required monitoring,
   (ii) undertakes a procedure notwithstanding the specific, written decision to the contrary by a monitor, or
   (iii) during the course of a procedure, refuses to comply with the monitor’s instructions and/or transfer control of the care of the patient to the monitor upon a specific demand to that effect made by the monitor.

(b) Such precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO, the President of the Medical Staff, the Chairperson of the Credentials Committee, the Chairperson of the Member’s or Allied Health Professional’s Department, the Chairperson of the Board of Directors and the Member or Allied Health Professional affected, and shall remain in effect unless or until modified by the Medical Executive Committee, the CEO or his/her designee, or the Board of Directors, or as provided in this Section 4.B or, if the procedures contained in Article 5 have been completed and such procedure has determined that such suspension be lifted.

(c) Any individual or body which exercises authority under this Section 4.B to suspend the Clinical Privileges of a Member or Allied Health Professional shall immediately report such action to the President of the Medical Staff and CEO so that appropriate further action can be taken in the matter.

4.B.2. Investigative Procedure

(a) An investigation of the matter resulting in precautionary suspension shall be immediately undertaken by the President of the Medical Staff or his/her designee. Upon completion of his/her investigation, the President of the Medical Staff (or his/her designee, as applicable) shall submit his/her written report to the Medical Executive Committee within five (5) days after the imposition of the precautionary suspension.
(b) The Medical Executive Committee shall undertake its review as soon as possible upon receipt of the report of the investigation and ordinarily within thirty (30) days of the imposition of the precautionary suspension. If such review has not been completed within thirty (30) days after initial imposition of the suspension, the Medical Executive Committee shall transmit the reasons for the delay to the Board of Directors so that the Board of Directors may consider whether the suspension should be lifted. In the event the suspension is so lifted, the Medical Executive Committee shall take such further action as is required, and in the manner specified in Section 4.A. Unless lifted by the Board of Directors, the Medical Executive Committee shall determine whether to continue or lift such suspension within thirty (30) days of the date of imposition and in the event it determines to continue such suspension shall so advise the CEO. In the event that the Medical Executive Committee fails to complete its investigation and determine whether to continue such suspension within said thirty (30) days, the suspension shall be automatically lifted at the expiration of such thirty (30) days, provided, however, nothing herein shall prohibit such suspension from thereafter being reimposed by any person or body authorized by this Policy to do so for the reasons set forth in this Policy and provided further that if the Medical Executive Committee has completed its investigation it may determine to maintain such suspension indefinitely.

c) Upon completion of its review of the matter, the Medical Executive Committee shall ratify, modify or overrule the action taken by the individual or body which imposed the precautionary suspension. Further, if the Medical Executive Committee has completed its investigation, it may determine to maintain such suspension indefinitely. If the action of the Medical Executive Committee continues to be adverse to the Practitioner or Allied Health Professional, the provisions of Article 5 shall be applicable. The suspended Member of Allied Health Professional shall be entitled to the procedural rights provided in Article 5 in the event of any suspension which has not been lifted prior to the fifteenth (15th) day after imposition or in the event of reimposition.

4.B.3. Care of Suspended Member’s or Allied Health Professional’s Patients

(a) Immediately upon the imposition of a precautionary suspension, the appropriate Department Chairperson or, if unavailable, either the President of the Medical Staff or the President-Elect of the Medical Staff, shall assign to another Member or Allied Health Professional, as appropriate, with appropriate Clinical Privileges responsibility for care of the suspended Member’s or Allied Health Professional’s patients still in the Hospital. The assignment shall be effective until such time as the suspension is lifted or the patients are discharged from the Hospital. Where feasible, the wishes of the patient shall be considered in the selection of the assigned appointee.

(b) It shall be the duty of the Medical Director, the President of the Medical Staff and the Department Chairperson to cooperate with the CEO in enforcing all suspensions.
4.C. TEMPORARY OR ADMINISTRATIVE SUSPENSIONS

4.C.1. Temporary Suspensions

A Member or Allied Health Professional shall be deemed to have voluntarily relinquished his/her Clinical Privileges and be deemed to be under administrative suspension (without any procedural rights otherwise provided in this Policy) in the event that any of the following events shall have occurred (and during the duration thereof):

(a) upon notification by the President of the Medical Staff, or his/her designee, of the Member’s or Allied Health Professional’s delinquency or failure to complete medical records within the applicable time periods in accordance with the Medical Staff Rules and Regulations and the Physician Incomplete/Delinquent Records and Suspensions Policy;

(b) upon notification by the President of the Medical Staff, or his/her designee, of the Member’s or Allied Health Professional’s failure to provide requested copies of license or DEA registration renewal, if applicable, as and when required in this Policy;

(c) failure to be adequately insured, or upon notification by the President of the Medical Staff or his/her designee of the Member’s or Allied Health Professional’s failure to provide evidence of adequate insurance, as required in this Policy;

(d) upon notification by the President of the Medical Staff, or his/her designee, of the Member’s or Allied Health Professional’s failure to satisfy Medical Staff, Department and committee meeting attendance requirements, if any, established in the Bylaws;

(e) in the case of a Medical Assistant, Physician Assistant or any other Allied Health Professional, unless authorized by law to practice independently without supervision of their employing Member of the Medical Staff, termination of such Allied Health Professional’s employment with a Member unless and until such Allied Health Professional is employed by another Member provided such employment by another Member has occurred within thirty (30) days of the prior employment termination (and such continued Privileges would not conflict with any exclusive contract) and such Member has submitted to the CEO or his/her designee appropriate documentation confirming such employment by such other Member and the other information required by Article 3 including, but not limited to, verification of insurance coverage and acknowledgment by such new employer of his/her responsibility for such Allied Health Professional;

(f) in the case of a Medical Assistant, Physician Assistant or any other Allied Health Professional unless authorized by law to practice independently without supervision of their employing Member of the Medical Staff, termination or suspension of the Clinical Privileges of such Allied Health Professional’s supervising employing Member unless such Allied Health Professional was employed by a group practice consisting of more than one Medical Staff Member.
and a Medical Staff Member of such group provides written confirmation of his/her responsibility for such Allied Health Professional;

(g) upon notification by the President of the Medical Staff, or his/her designee, of the Member’s failure to maintain an alternate with equivalent Clinical Privileges as required in Section 2.B.2.(d)(28), unless waived by the Board of Directors; or

(h) failure of a Member to pay required Medical Staff dues within 30 days of their due date.

Upon correction of such deficiencies, the Member or Allied Health Professional shall so notify the President of the Medical Staff or his/her designee. If the President of the Medical Staff agrees that such matter has been corrected he/she shall notify the Member or Allied Health Professional that his/her administrative suspension has been lifted and his/her Clinical Privileges have been reinstated. However, in the event the Member or Allied Health Professional shall fail to remedy or correct the basis for such suspension, [including re-employment of the Allied Health Professional as described in subparagraph (e) above or reinstatement of the Allied Health Professional’s employing Member’s Clinical Privileges as described in subparagraph (f) above] (and failure to notify the President of the Medical Staff of a correction shall be conclusive of the failure to correct any of such deficiencies) within six (6) months from the effective date of suspension, or the Member or Allied Health Professional has been suspended more than three (3) times during a calendar year for delinquency or failure to complete medical records as provided in subparagraph (a) above, the Medical Staff appointment of such Member and/or Clinical Privileges of such Member or Allied Health Professional will be deemed voluntarily surrendered and terminated and such Member or Allied Health Professional shall be deemed to have voluntarily resigned from the Medical Staff or such Allied Health Professional shall be deemed to have voluntarily surrendered his/her Clinical Privileges, without any procedural rights under Article 5.


A Member’s Medical Staff appointment and Clinical Privileges or an Allied Health Professional’s Clinical Privileges shall automatically cease and terminate upon:

(a) the revocation, termination, or suspension (in whole or in part) of the Member’s, professional license or certification in Montana. Partial licensure restrictions will result in a similar restriction of the Member’s or Allied Health Professional’s Clinical Privileges;

(b) the Member’s or Allied Health Professional’s conviction of, pleading guilty to a charge of, or entering a plea of no contest to a charge of, a crime which reasonably relates to the ability of the Member or Allied Health Professional to exercise the Clinical Privileges granted to him/her, whether or not sentence has been imposed, sentence suspended or probation granted;

(c) exclusion (debarment) from the Medicare, Medicaid or other government sponsored healthcare program;
(d) failure of a Member to pay required Medical Staff dues within 60 days of their due date; or

(e) termination of any contractual arrangement between the Hospital and a Member (or Member’s group) or Allied Health Professional where such contract provides that upon termination thereof, the Member’s appointment and/or Clinical Privileges or the Allied Health Professional’s Clinical Privileges shall terminate and be deemed to have been voluntarily surrendered.

In the event any of the events described in (a) through (e) of this Section 4.C.2 shall occur, the Medical Staff appointment and Clinical Privileges of such Member or Clinical Privileges of such Allied Health Professional will be deemed voluntarily surrendered and terminated and such Member shall be deemed to have voluntarily resigned from the Medical Staff, without in any such cases any procedural rights under Article 5.

4.D. PROCEDURE FOR LEAVE OF ABSENCE

Practitioners appointed to the Medical Staff and Allied Health Professionals having been granted Clinical Privileges may, for good cause, be granted leaves of absence by the Board of Directors for a stated period of time not to exceed one (1) year, unless otherwise recommended by the Medical Executive Committee in the event such leave is for military service, a fellowship training program or because of injury or illness. Absence for longer than one (1) year shall constitute voluntary resignation of the Member’s Medical Staff appointment and the voluntary surrender of a Member’s or Allied Health Professional’s Clinical Privileges unless an exception is granted by the Board of Directors.

Requests for leaves of absence shall be made by submitting a written request, on designated form, to the Credentials Committee, and the CEO or his/her designee and shall state the beginning and expected ending dates of the requested leave and reasons therefore. A leave of absence is to be requested when a Member’s or Allied Health Provider’s absence from his/her practice is 90 days or more. During the period of the leave, the Member or Allied Health Professional shall not exercise Clinical Privileges at the Hospital, and his or her rights and responsibilities shall be inactive. In the event that such request is approved, the Member or Allied Health professional shall make necessary arrangements to provide alternate coverage for proper and necessary patient care during his/her absence and shall complete all of his/her patient medical records before beginning his/her leave of absence. Failure to request a leave of absence will result in a referral to the Credentials Committee for review and may be grounds for revocation of appointment and Privileges.

At the conclusion of the leave of absence, the Member or Allied Health Professional may be reinstated, upon filing a written statement with the CEO summarizing the professional activities, including fellowship or other training, if any, undertaken during the leave of absence and certifying that the Member or Allied Health Professional is physically and mentally capable of resuming a
hospital practice without imposing a direct threat to the safety or welfare of patients, himself/herself and others, with or without accommodation and if with accommodation the nature of the needed accommodation. Such application shall be submitted not later than thirty (30) days prior to the desired termination of leave. The Member or Allied Health Professional shall also provide documentation concerning completion of any outstanding medical records and such other information as may be requested by the Credentials Committee, the Medical Executive Committee or the Board of Directors at that time. The Credentials Committee shall review such request and recommend to the Medical Executive Committee and the Board of Directors concerning the requested reinstatement by the Board of Directors, provided, however, if such leave of absence was for active service in a branch of the United States military (including National Guard), upon receipt of discharge papers and review by the appropriate Department Chairperson, the Department Chairperson, if satisfied as to the abilities of the Member or Allied Heath Professional, may immediately reinstate the Member or Allied Health Professional provided that the Member’s or Allied Health Professional’s appointment term at the time of call for active duty has not expired.

If the leave was for medical reasons, then the Member or Allied Health Professional must submit a report from his or her attending physician to the Credentials Committee indicating:

(a) that such Member or Allied Health Professional is able to perform the essential functions of the Member’s or Allied Health Professional’s Clinical Privileges without posing a direct threat to the health or safety of the Member or Allied Health Professional, patients, or others;

(b) whether there is a need for an accommodation to the Member or Allied Health Professional to enable the Member or Allied Health Professional to perform such Privileges; and

(c) what accommodation is suggested or required, if applicable.

In acting upon the request for reinstatement, the Board of Directors may approve reinstatement for the Member or Allied Health Professional either to the same or a different staff category, and may limit or modify the Clinical Privileges to be extended to the Member or Allied Health Professional upon reinstatement.

The Member’s or Allied Health Professional’s failure, without good cause, to request reinstatement from a leave of absence within one (1) year shall be deemed a voluntary resignation of appointment and/or Clinical Privileges.

4.E. CONFIDENTIALITY AND REPORTING

Actions taken and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted.
by the Board of Directors. In addition, reports of actions taken pursuant to this Policy shall be made by the CEO to such governmental agencies as may be required by law.

4.F. PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are deemed to be covered by the provisions of Section 50-16-201 and Section 37-2-201 of the Montana Code or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this Policy shall be considered to be acting on behalf of the Hospital and the Board of Directors when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.

The Medical Staff acknowledges that one of its important functions is to assure the Board of Directors that the care provided to patients within the Hospital is of the highest quality and in accordance with current standards, trends and patient care protocols. To assure such quality and improve the care provided, it is essential to evaluate the care provided by the Members and Allied Health Professionals within the Hospital and to provide feedback, compare such care with such provider’s peers and provide education to such providers to achieve such goals. Committees of the Medical Staff have been established to evaluate the provision of patient care services within the Hospital generally and as to that provided by specific providers. These committees include, among others, the Credentials Committee and Medical Executive Committee. In addition, certain members of the Medical Staff including, but not limited to, Department Chairpersons, Section Chairpersons and such members of the Medical Staff with whom such persons may consult for their subspecialty advice in the performance of such peer review (“Subspecialty Peer Review Consultants”) also individually perform a peer review role in advising members of their respective Departments or Sections, as applicable, or programs, with respect to providers’ performance, comparison with peers, trends and suggest methods for improving patient care. The Medical Staff recognizes that such Department Chairpersons, Section Chairpersons and Subspecialty Peer Review Consultants play an integral part in performance improvement, utilization and risk management, assessment of care provided, Member and Allied Health Professional credentialing and otherwise in the maintenance or improvement of the quality, appropriateness and efficiency of patient care in the Hospital by such providers (collectively, “Peer Review Activities”). Such committees of the Medical Staff and each Department Chairperson, Section Chairperson and Subspecialty Peer Review Consultants while performing Peer Review Activities are hereby appointed and authorized by the Medical Staff to function as professional and medical peer review committees of the Medical Staff and the Hospital. In such capacity, such committees and Department Chairpersons, section Chairpersons and Subspecialty Peer Review Consultants are each considered, for the purposes of Section 37-2-201 of the
Montana Code, to be a “peer review committee” whose peer review functions shall be accorded such confidentiality and Privileges as are available to the greatest extent allowed by law.

4.G. INFORMAL PROCEEDINGS

Nothing in this Policy or the Bylaws shall preclude collegial or informal efforts to address questions or concerns relating to a Member’s or Allied Health Professional’s practice and conduct in the Hospital.

ARTICLE 5

HEARING AND APPEAL PROCEDURES

5.A. BASIS FOR HEARING

5.A.1. General Grounds for Entitlement to Hearing

Except as otherwise specifically provided in this Policy, an applicant, a Member holding a Medical Staff appointment, and an Allied Health Professional applying for or holding Clinical Privileges shall be entitled to request a hearing and appeal of certain actions or recommendations as described in and in accordance with this Policy whenever:

(a) an unfavorable recommendation has been made by, or adverse action taken by, or adverse action has been approved by the Medical Executive Committee or the Board of Directors (unless the basis therefore is described in Section 5.A.3) regarding any of the following:

(1) denial of initial Medical Staff appointment;
(2) denial of Medical Staff reappointment;
(3) revocation of Medical Staff appointment;
(4) denial of requested advancement in Medical Staff category;
(5) denial of requested initial or additional Clinical Privileges (other than temporary, emergency, locum tenens or disaster Privileges), provided the Practitioner or Allied Health Professional has satisfied the basic criteria of training, education, experience and, if applicable, Departmental affiliation established for such Privileges;
(6) denial of requested Department;
(7) decrease or reduction in or revocation of Clinical Privileges;
(8) suspension of Medical Staff appointment or Clinical Privileges, either in whole or in part, for a period in excess of fourteen (14) days unless otherwise provided in this Policy;

(9) denial of a request to return to active Medical Staff or active status of an Allied Health Professional following a temporary leave of absence; or

(10) such other adverse action or recommendation which under applicable federal or state law requires giving a Practitioner or Allied Health Professional the right to a hearing.

(b) action has been taken by any person or body authorized by this Policy to do so to suspend the Clinical Privileges, either in whole or in part, of a Member or Allied Health Professional, except as provided in subparagraphs 5.A.3(h), (i), (j), (k) or (l) below, for a period in excess of fourteen (14) days and such suspension was continued beyond such fourteen (14) days by the Executive Committee or the Board fails to recommend lifting the suspension after its preliminary review pursuant to Article 5.D prior to the 15th day.

Notwithstanding anything contained in subparagraph (a)(8) or (b) of this Section 5.A.1, if the Medical Executive Committee upon conclusion of any investigation while a precautionary suspension is pending removes or terminates such suspension and restores the Member’s or Allied Health Professional’s Clinical Privileges prior to the thirty-first (31st) day after imposition of such suspension, the affected Member or Allied Health Professional shall have no right to seek review or appeal of such action and if a request for an appeal has been made prior to removal or termination of such suspension, such request for appeal shall be deemed withdrawn and of no further effect.

5.A.2. Must be Action by Certain Persons, Committees or the Board of Directors

A recommendation or action enumerated in Section 5.A.1(a) shall be deemed adverse and entitle a Practitioner or Allied Health Professional to a hearing only when it:

(a) has been recommended by, it is the action that has been taken by, or the action has been approved by the Medical Executive Committee;

(b) has been recommended by or the action has been taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no prior right to a hearing existed;

(c) has been recommended by or the action has been taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Medical Executive Committee; or

(d) constitutes action described in Section 5.A.1(b).
5.A.3. Actions Which Do Not Give Right to Hearing

No recommendation or action except those enumerated in Section 5.A.1 and no action described in this Section 5.A.3 even though it might be enumerated in Section 5.A.1 shall constitute grounds for or entitle the Practitioner or Allied Health Professional to request a hearing or appeal of the matter. As examples and not as a limitation, none of the following matters shall entitle a Practitioner or Allied Health Professional to a hearing under this Policy:

(a) an oral or written reprimand, warning or admonition;

(b) imposition of a requirement that the Practitioner or Allied Health Professional must be supervised while performing certain procedures, unless such requirement prevents the Practitioner or Allied Health Professional from exercising his/her Clinical Privileges;

(c) denial of requested Clinical Privileges because the Practitioner or Allied Health Professional failed to satisfy the basic qualifications or criteria of training, education, experience (including performance of a minimum number of procedures or related procedures, if any, or, if applicable, Departmental affiliation established for the granting of Privileges for a specific procedure or procedures), as set forth in the Bylaws or this Policy, any Medical Staff credentials policy or privileging criteria;

(d) ineligibility for Medical Staff appointment or reappointment or the Clinical Privileges requested because a department has been closed to new members, the Board of Directors has determined that certain medical services will only be provided or performed by certain types of healthcare providers that do not include the Allied Health Professional’s or Practitioner’s specialty, or there exists an exclusive contract limiting the performance of Privileges within the specialty in which the Practitioner or Allied Health Professional practices or the Privileges which the Practitioner or Allied Health Professional has requested to one or more Physicians and/or Allied Health Professionals;

(e) termination or revocation of Medical Staff appointment, Clinical Privileges, in whole or in part, or Departmental affiliation because the Hospital has determined to close a Department to new members, or grant an exclusive contract limiting the performance of Privileges within the specialty in which the Practitioner or Allied Health Professional practices to one or more Physicians or specialty;

(f) ineligibility for Medical Staff appointment or reappointment because of lack of facilities or equipment for the service or procedure which the Practitioner or Allied Health Professional intends to provide;

(g) ineligibility for requested Clinical Privileges because the Hospital has elected not to perform, or does not provide, the procedure for which Clinical Privileges are sought;
(h) reduction, suspension or revocation of Medical Staff appointment, category of appointment or Clinical Privileges or denial of Medical Staff or Department reappointment because of the failure of the Practitioner or Allied Health Professional to comply with requirements of the Bylaws including, but not limited to, any required attendance at committee, Department, or general Medical Staff meetings, payment of required dues, compliance with medical records requirements, failure to maintain required insurance, exclusion from Medicare, Medicaid or other government sponsored healthcare program, or loss, revocation or suspension of state or other required licensure or registration, or for any other matter resulting in an automatic administrative suspension or termination of Medical Staff appointment or Clinical Privileges;

(i) reduction, suspension or revocation of Medical Staff appointment or category of appointment or denial of Medical Staff reappointment because of the Practitioner’s failure to satisfy the requirements for appointment to the Medical Staff category to which appointment or reappointment was sought, as such requirements are set forth in Article 2 of the Bylaws;

(j) denial of initial appointment or reappointment to the Medical Staff or of the initial grant or renewal of Clinical Privileges because of the Practitioner’s or Allied Health Professional’s failure to demonstrate evidence of the satisfaction of basic requirements for appointment or reappointment or granting of Clinical Privileges, including, but not limited to, licensure, maintenance of required professional liability insurance, any required continuing education, or any other criteria for appointment or reappointment or granting of Clinical Privileges as set forth in this Policy;

(k) voluntary suspension or relinquishment of Clinical Privileges or Medical Staff membership, as provided for elsewhere in this Policy, including but not limited to Section 4.C;

(l) the imposition of monitoring, proctoring, review or consultation, so long as such requirements are not a condition to the exercise of Privileges;

(m) the imposition of a requirement for retraining, additional training or continuing education;

(n) the imposition of a requirement that the Practitioner or Allied Health Professional must obtain a medical (including psychological) evaluation or counseling;

(o) denial of a request for or termination or revocation of temporary, emergency, locum tenens or disaster Clinical Privileges;

(p) suspension of Privileges, either in whole or in part, or Medical Staff appointment for less than fifteen (15) days and during which an investigation is being conducted to determine the need for further action;
(q) termination or revocation of Medical Staff appointment or reduction, suspension, termination or revocation of Clinical Privileges, either in whole or in part, because the Hospital has eliminated a category of the Medical Staff;

(r) relinquishment of Clinical Privileges due to failure of the Member or Allied Health Professional to complete the terms of a provisional monitoring program;

(s) where the Practitioner or Allied Health Professional is deemed to have withdrawn his/her application for appointment, re-appointment or for Clinical Privileges pursuant to any provision of this Policy;

(t) appointment or reappointment or granting of Clinical Privileges for a term of less than two (2) years;

(u) revocation or termination of Clinical Privileges because the Hospital or Board of Directors has determined that certain procedures or practices will not be permitted to be performed in the Hospital;

(v) placement on probationary or other conditional status;

(w) continuation of provisional appointment or Clinical Privileges;

(x) failure to place a Practitioner or any on-call or interpretation roster, or removal of any Practitioner from such roster; or

(y) any other action for which no hearing is required to be provided pursuant to the Health Care Quality Improvement Act of 1986 or any action or recommendation which is not reportable to the National Practitioner Data Bank.

No report of any action taken based on a Practitioner’s or Allied Health Professional’s involuntary exclusion from a health care program funded, in whole or in part, by the federal government shall be reported to the Montana Board of Medical Examiners or other state board or agency applicable to the provider or the National Practitioner Data Bank relating to any action or extent described in (a) through (y).

5.B. THE HEARING

5.B.1. Notice of Adverse Action or Recommendation

When an action or recommendation is made which, according to this Policy, entitles a Practitioner or Allied Health Professional to appeal such action or recommendation and seek a hearing prior to a final decision of the Board of Directors, the affected Practitioner or Allied Health Professional shall promptly be given Special Notice by the CEO of such action or recommendation. This notice shall contain:

(a) a statement of the recommendation made or action taken and the general reasons or basis for such action or recommendation;
(b) advice that the Practitioner or Allied Health Professional has the right, within thirty (30) days of receipt of the notice (or from the later date of any meeting with the Medical Executive Committee pursuant to Section 4.A.7, if applicable), to request a hearing on the recommendation or action taken and that if the Member or Allied Health Professional is then under suspension the Member or Allied Health Professional may request an early hearing date;

(c) a notice that failure to request a hearing within thirty (30) days shall constitute a waiver of the right to a hearing and to any appellate review of the matter and shall be deemed acceptance of the recommendation or action;

(d) a summary of the Practitioner’s or Allied Health Professional’s rights in the hearing; and

(e) a copy of this Article outlining the rights in the hearing procedure as provided for in this Policy.

5.B.2. Request for Hearing

A Practitioner or Allied Health Professional shall have thirty (30) days following the date of receipt (which date shall also mean the date of any attempted or refused delivery) of the Special Notice given pursuant to Section 5.B.1 or from the date of any meeting with the Medical Executive Committee pursuant to Section 4.A.7 within which to request the hearing. The request shall be in writing delivered to the President of the Medical Staff or his/her designee, CEO or his/her designee either in person or by United States certified or registered.

5.B.3. Waiver by Failure to Request a Hearing

If a Practitioner or Allied Health Professional fails to appeal such action by requesting a hearing within the time and in the manner specified in Section 5.B.2, the Practitioner or Allied Health Professional shall be deemed to have waived any right to appeal the action taken or recommendation and to such hearing to which he/she might otherwise have been entitled and to have accepted the action or recommendation involved. Such waiver in connection with:

(a) an adverse recommendation, action or decision by the Board of Directors shall constitute acceptance of that decision or action, which shall thereupon become effective as the final decision of the Board of Directors; or

(b) an adverse recommendation by the Medical Executive Committee or action by a person or body authorized by this Policy to take action which prompted the right to a hearing shall constitute acceptance of that recommendation or action, which shall thereupon become and remain effective pending the final decision of the Board of Directors. Unless such recommendation or action shall have been made by the Medical Executive Committee or the Board of Directors, such action or recommendation shall be considered by the Medical Executive Committee at its next regular meeting following the effective date of such waiver and the Medical
Executive Committee shall report its recommendation to the Board of Directors. The Board of Directors shall consider the committee’s recommendation at its next regular meeting following the effective date of such waiver or meeting of the Medical Executive Committee as provided in the immediately preceding sentence. In its deliberations, the Board shall review the recommendation and may consider all relevant information from such Committee or from any other source. If the Board’s action on the matter is in accord with the Medical Executive Committee’s recommendation, such action shall constitute the final decision of the Board of Directors. If the Board of Directors’ action has the effect of changing the Medical Executive Committee’s recommendation, the matter shall be submitted to a Joint Conference Review Committee as provided in Section 5.E.8(b). The Board of Directors’ action on the matter following receipt of the Joint Conference Review Committee’s recommendation shall constitute its final decision.


(a) As soon as practical after receipt of a timely request for a hearing from the affected Practitioner or Allied Health Professional, the CEO shall schedule the date upon which the hearing shall be held and shall advise the Practitioner or Allied Health Professional by Special Notice not later than thirty (30) days prior to the scheduled hearing date (except in the case of a hearing for a Member or Allied Health Professional who is under a suspension then in effect, and request for an expedited hearing is received from the affected Practitioner or Allied Health Professional in which event such notice shall be given not later than ten (10) days prior to the scheduled hearing date) of the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses, so far as are then known, who are expected to give testimony or present evidence at the hearing in support of the action taken or recommended by the Medical Executive Committee or the Board of Directors, as applicable, including a brief summary of their expected testimony; and

(3) a concise written statement of the Practitioner’s or Allied Health Professional’s alleged acts or omissions and/or the specific reasons or the subject matter which is the basis for the recommendation or action, together with the list of specific or representative patient records, if applicable, and description of the incident(s) or other information supporting the recommendation or action. This statement, the list of supporting patient record numbers, if applicable, witness list, and other supporting information may be amended or added to at any time, even during the hearing so long as the additional material is relevant and the Practitioner or Allied Health Professional and his/her counsel, if represented, shall have sufficient time to study this additional information to be able to rebut it.
The hearing date shall be scheduled by the CEO for a date not sooner than thirty (30) days nor more than ninety (90) days after the date of receipt by the CEO of a timely request for a hearing; provided, however, that a hearing for a Practitioner or Allied Health Professional who is under suspension then in effect shall be scheduled by the CEO and held as soon as the arrangements for it may reasonably be made if requested by the affected Practitioner or Allied Health Professional, but not later than thirty (30) days after the date of receipt of the request for a hearing or as otherwise agreed upon by the parties.

5.B.5. Witness Lists

(a) Within ten (10) days after receiving notice of the hearing (but in no event less than five (5) days prior to the scheduled date of the hearing in the event of a requested expedited hearing for a Practitioner or Allied Health Professional then under suspension), the Practitioner or Allied Health Professional requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his or her behalf, including a brief summary of their expected testimony. In keeping with the purpose of the hearing, neither patients nor patients’ relatives shall ordinarily be called as witnesses. Patients and patients’ relatives shall not be called as character witnesses. Patients and patients’ relatives may, however, be permitted to testify only if the evidence to be provided by the patient or patients’ relatives relates directly to any incident or matter of which they have direct knowledge and the subject of their testimony could not reasonably be adequately provided by available healthcare providers and is not otherwise attainable.

(b) The witness list of either party may, in the discretion of the Presiding Officer, if any, or Hearing Panel Chairperson, be supplemented or amended at any time either prior to or during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses as set forth in Section 5.B.6.

5.B.6. Judicial Review Committee, Committee Chairperson, Presiding Officer and Hearing Officer

(a) Judicial Review Committee Composition

(1) When a hearing which is occasioned by an action or recommendation which entitles a Practitioner or Allied Health Professional to a hearing pursuant to Section 5.A.1 (except action taken or recommended by the Board of Directors or which is described in Section 5.A.3), is requested, the CEO, acting for the Board of Directors and after considering the recommendations of the President of the Medical Staff, shall appoint a Judicial Review Committee which shall be composed of not less than three (3) members. Such Committee may include appointment of one or more alternates. The Judicial Review Committee shall be composed of (i) Medical Staff Members and/or Allied Health Professionals (if
appropriate) who have not actively participated in the consideration of the matter involved at any previous level and which do not include any individual described in subparagraph (3), (ii) Physicians, Allied Health Professionals (as appropriate) or lay persons who are not connected with the Hospital or (iii) any combination of such persons. Any member of the Judicial Review Committee, including any alternate, who participates in the entire hearing, or reviews the transcript of any portions of the hearing for which the Committee member is not in personal attendance, may be permitted to participate in the deliberations and to vote on the recommendations of the Hearing Panel at the discretion of the Committee Chairperson or Presiding Officer.

(2) When a hearing which is occasioned by the action or recommendation of the Board of Directors pursuant to Section 5.A.2(b) or (c) is requested, the CEO, acting for the Board of directors and after considering the recommendations of the President of the Medical Staff unless he/she is subject of the hearing, shall appoint a Judicial Review Committee which shall be composed of not less than three (3) members. Such Committee may include appointment of one or more alternates. The Judicial Review Committee shall be composed of (i) Medical Staff Members and/or Allied Health Professionals who have not actively participated in the consideration of the matter involved at any previous level, and who do not include any individual described in subparagraph (3), or members of the Board who shall not have actively participated in the matter involved, (ii) Physicians, Allied Health professionals (as appropriate) or lay persons who are not connected with the Hospital or (iii) any combination of such persons. Any member of the Judicial Review Committee, including any alternate, who participates in the entire hearing, or reviews the transcript of any portions of the hearing for which the panel member is not in personal attendance, may be permitted to participate in the deliberations and to vote on the recommendations of the Judicial Review Committee at the discretion of the Committee Chairperson or Presiding Officer.

(3) The Judicial Review Committee shall not include any individual who is in direct economic competition with the affected Practitioner or Allied Health Professional, who would gain any directed financial benefit from the outcome, who have acted as accusers, investigators, fact finders, initial decision-makers, who have actively participated in the consideration of the matter leading up to the recommendation or action, or any such individual who is professionally associated with or related to the affected Practitioner or Allied Health Professional. Such appointment shall include designation of one of the members of the Judicial Review Committee as the Chairperson or the Presiding Officer. Knowledge of the matter involved or participation in the investigation of the underlying matter shall not preclude any individual from serving as a member of the Judicial Review Committee.
(4) The Practitioner or Allied Health Professional shall be notified of the prospective members of the Judicial Review Committee and if the Practitioner or Allied Health Professional has any reasonable objection to any proposed committee member, the Practitioner or Allied Health Professional shall, within ten calendar (10) days after notification, state the objection in writing and the reasons for the objection. The Medical Staff President and the CEO shall, after considering such objections, decide in their discretion whether to replace any person objected to and the Practitioner or Allied Health Professional shall be notified of the final members of the Hearing Panel.

(5) The Judicial Review Committee may make a recommendation to the Medical Executive Committee (or the Board of Directors as the case may be) as long as a majority of the committee members, including any alternates, have attended all the hearings or read the transcript of any hearings for which a panel member was not in personal attendance. A majority of the members of the Judicial Review Committee, including any alternates shall constitute a quorum for purposes of conducting a hearing.

(b) Presiding Officer

(1) In lieu of appointing a member of the Judicial Review Committee as Chairperson, the CEO may appoint an attorney at law, including a judge or retired judge, as Presiding Officer. Such Presiding Officer may be legal counsel to the Hospital, but shall not act as a prosecuting officer, or as an advocate for either party at the hearing. The Presiding Officer may participate in the private deliberations of the Judicial Review Committee and be a legal advisor to it, but shall not be entitled to vote on its recommendations. Legal counsel may thereafter continue to advise the Board of Directors on the matter.

(2) If no Presiding Officer has been appointed, a Chairperson of the Judicial Review Committee shall be designated by the CEO, shall serve as the Presiding Officer, and shall be entitled to one (1) vote.

(3) The Presiding Officer (or Judicial Review Committee Chairperson) shall:

   (i) act in an impartial manner to insure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both parties, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

   (ii) maintain decorum throughout the hearing;
(iii) determine the order of procedure throughout the hearing, including limiting duplicative or redundant testimony and witnesses or testimony which is not deemed relevant to the issue(s) presented, and excluding expert witnesses or others from the room during the course of the proceedings when they are not providing testimony;

(iv) have the authority and discretion, in accordance with this Policy, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;

(v) act in such a way that all information relevant to the continued appointment or Clinical Privileges of the Practitioner or Allied Health Professional requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and

(vi) conduct argument by counsel on procedural points outside the presence of the Judicial Review Committee unless the committee wishes to be present;

(4) The Presiding Officer may be advised by legal counsel to the Hospital or other counsel engaged for the purpose of advising the Judicial Review Committee and/or the Presiding Officer.

(c) Hearing Officer

(1) As an alternative to the Judicial Review Committee described in paragraph (a) of this Section 5.B.6, the CEO, after consulting with the President of the Medical Staff (and the Chairman of the Board of Directors if the hearing was occasioned by a Board determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be performed by the Judicial Review Committee. The Hearing Officer shall preferably be an attorney at law, including a judge or former judge, or some other individual capable of conducting a hearing.

(2) The Hearing Officer may not be in direct economic competition with the Practitioner or Allied Health Professional requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either party at the hearing. In the event a Hearing Officer is appointed instead of a Judicial Review Committee, all references in this Article to the “Judicial Review Committee” or “Presiding Officer” shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(3) In the event of the appointment of a Hearing Officer as provided in this subparagraph (c), the CEO shall immediately notify the affected Practitioner or Allied Health Professional of such action and the identity of such person who shall be reasonably acceptable to the Practitioner or Allied Health Professional. In the event such person is unacceptable to the Practitioner or Allied Health Professional, the Practitioner or Allied Health
Professional shall so advise the CEO within ten (10) days (and the Practitioner or Allied Health Professional shall be notified of such duty and right) of his or her objection and the basis therefor, which shall not be arbitrary or unreasonable. Failure to so object within said ten (10) days shall be deemed as acceptance of such Hearing Officer. If the CEO accepts the basis for the Practitioner’s or Allied Health Professional’s objection and desires to appoint a substitute Hearing Officer, the CEO and affected Practitioner or Allied Health Professional shall agree on such person. The CEO may elect, however, not to appoint a substitute Hearing Officer, in which event a Judicial Review Committee shall be appointed as otherwise provided herein as quickly as reasonably possible.

5.C. HEARING PROCEDURE

5.C.1. Nature of Hearing

The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in this Policy.

5.C.2. Pre-Hearing Conference

Prior to the scheduled date of the Hearing, the Hearing Officer or Presiding Officer, as the case may be, shall schedule a conference between the Practitioner or Allied Health Professional and representatives of the Medical Staff or Board of Directors, as the case may be, and/or their counsel to discuss preliminary matters concerning the hearing in order that the hearing may be conducted in an orderly and expeditious fashion. The Hearing Officer or Presiding Officer may rule on preliminary matters and define the scope of the hearing, including any limitations on witnesses (either number or subject matter and whether certain witnesses shall be excluded during portions of the proceedings), objections to documents or witnesses (as provided in Section 5.B.6(b)(3)(iii)), and whether evidence relating to other Members or Allied Health Professionals, if applicable, will be admissible.

5.C.3. Limited Right of Discovery

(a) There shall be no right to pre-hearing discovery for either party except as specifically provided in this Section 5.C.3. There shall be no right to seek information regarding other Members or Allied Health Professionals. Nothing shall prevent either party, however, from otherwise preparing its position, including interviewing witnesses (subject to the limitations in subparagraph (c) of this Section 5.C.3) and obtaining statements therefrom. The Practitioner or Allied Health Professional requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:
(1) copies of, or reasonable access to, all patient medical records referenced in the statement of reasons, at the Practitioner’s or Allied Health Professional’s expense;

(2) reports of experts relied upon by the Medical Executive Committee, or Board of Directors, as the case may be;

(3) redacted copies of relevant committee or Department minutes (such provision shall not constitute a waiver of the state peer review protection statute, however); and

(4) copies of any other documents relied upon by the Medical Executive Committee, or Board of Directors, as the case may be, provided that the identity of individuals may be redacted.

(b) There shall be no right to discover the name of any individual who has produced evidence relating to the charges made against the provider who requested the hearing unless such individual is to be called as a witness at the hearing or unless the deposition or other written statement of such individual is to be entered into evidence at the hearing.

(c) Prior to the hearing, on dates set by the Presiding Officer or Committee Chairperson or agreed upon by both parties or, if represented by counsel, counsel for both parties, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known shall be submitted in writing in advance of the hearing. The Presiding Officer or Committee Chairperson shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(d) Neither the affected Practitioner or Allied Health Professional, nor his/her attorney, if represented, nor anyone else on his/her behalf shall contact Hospital employees concerning the subject matter of the hearing, unless such is specifically agreed upon by counsel for the Hospital.

5.C.4. Failure to Appear

Failure, without good cause, of the Practitioner or Allied Health Professional requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a withdrawal of the Practitioner’s or Allied Health Professional’s request for a hearing and waiver of the Practitioner’s or Allied Health Professional’s rights to appeal the adverse action or recommendation and shall further constitute a voluntary acceptance of the recommendations or actions pending in the same manner and with the same consequences as provided in Section 5.B.3.

5.C.5. Record of Hearing

The Judicial Review Committee shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of
such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the Practitioner or Allied Health Professional requesting the hearing at the Practitioner’s or Allied Health Professional’s expense. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

5.C.6. Rights of Both Parties

(a) At the hearing both parties shall have the following rights, subject to reasonable limits determined by the Presiding Officer or Judicial Review Committee Chairperson:

1. to make a brief opening statement to describe generally the nature and subject of the hearing in order to provide the Judicial Review Committee with an overview of the matter;

2. to call and examine witnesses to the extent available;

3. to introduce exhibits and present other evidence which is determined by the Presiding Officer or Judicial Review Committee Chairperson to be relevant to the hearing and non-duplicative in accordance with this Article;

4. to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

5. representation by counsel licensed to practice in Montana who may call, examine, and cross-examine witnesses and present the case. Counsel shall not be allowed to answer questions directed to the Practitioner or Allied Health Professional. The affected Practitioner or Allied Health Professional may elect, as an alternative, to be represented by another person of the Practitioner’s or Allied Health Professional’s choice. Both parties shall notify the other of the name of their counsel (or other representative as the case may be) at least ten (10) days prior to the date of the hearing (five (5) days in case of a hearing scheduled sooner than thirty (30) days after receipt of the request for an expedited hearing), provided, however, that either party may change such counsel at any time without prejudice; and

6. to submit a written statement at the close of the hearing or within not later than five (5) business days after the close of the hearing, as determined by the Presiding Officer or the Chairperson of the Judicial Review Committee.

(b) If the Practitioner or Allied Health Professional who requested a hearing does not testify in his or her own behalf, the Practitioner or Allied Health Professional may be called and examined as if under cross-examination.
5.C.7. Admissibility of Evidence

The hearing shall not be conducted strictly in accordance with the rules of evidence. Hearsay evidence shall not be excluded merely because it constitutes hearsay. Any relevant evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law unless limited pursuant to Section C.2 or otherwise by the Presiding Officer or Chairperson or the Judicial Review Committee. Each party shall have the right to submit a memorandum concerning any issue of law or fact, and points and authorities supporting it, and such memorandum shall become part of the hearing record, provided that such memorandum must be submitted to the Judicial Review Committee at least seventy-two (72) hours before the scheduled date of the hearing or such other date as the Presiding Officer or Committee Chairperson shall determine. The Judicial Review Committee may request such a memorandum to be filed, following the close of the hearing by a date set by the Judicial Review Committee. Members of the Judicial Review Committee may also question the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

5.C.8. Official Notice

The Presiding Officer shall have the discretion to take official notice, either before or after the submissions of the matter for decision, of any matters, either technical or scientific, relating to the issues under consideration and of any facts that could have been judicially noticed by the courts of the State of Montana. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the hearing record. Either party shall have the opportunity, if timely made, to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority, the sufficiency of presentation to be determined by the Presiding Officer. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted by official notice. The Judicial Review Committee shall also be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered pursuant to this Policy in connection with applications for appointment or reappointment to the Medical Staff or for the granting of Clinical Privileges.

5.C.9. Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this Policy may be requested by anyone but shall be permitted only by the Judicial Review Committee, or its Chairperson acting on the committee’s behalf, on a showing of good cause, except upon the agreement of both parties and except that the Practitioner or Allied Health Professional shall be granted a request for a later hearing when the action involves a Practitioner or Allied Health Professional who is under suspension then in effect if the Practitioner or Allied Health Professional initially requested an expedited hearing and believes he/she needs additional time to prepare for such hearing.
5.C.10. Burden of Proof

(a) In all cases in which a hearing is conducted under this Policy, the Medical Executive Committee or the Board of Directors, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation or action. Thereafter, the burden shall shift to the Practitioner or Allied Health Professional who requested the hearing to present evidence.

(b) In all cases in which a hearing is conducted under this Policy, after all the evidence has been presented by both parties, the Judicial Review Committee shall recommend in favor of the body whose action prompted the hearing unless it finds that the Practitioner or Allied Health Professional who requested the hearing has proved, by clear and convincing evidence, that the recommendation or action that prompted the hearing was arbitrary, unreasonable, capricious, or not supported by any rational basis.

5.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

5.D.1. Basis of Decision

The decision of the Judicial Review Committee shall be based on the evidence produced at the hearing including matters to which official notice was taken and shall not be limited to the evidence before the body whose action prompted the hearing in determining whether such action was arbitrary, unreasonable, capricious, or not supported by any rational basis. This evidence may consist of the following:

(a) oral testimony of witnesses;

(b) memoranda concerning any issue of law or fact and points and authorities supporting it presented in connection with the hearing;

(c) any information regarding the Practitioner or Allied Health Professional who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

(d) any and all applications, references, and accompanying documents;

(e) other documented evidence, including medical records; and

(f) any other evidence that has been admitted, including matters to which official notice was taken.

5.D.2. Adjournment and Conclusion

The Presiding Officer or Judicial Review Committee Chairperson may adjourn the hearing and reconvene the same at the convenience and with the agreement of the
participants or for the purpose of obtaining new or additional evidence or consultation without additional notice. Upon conclusion of the presentation of oral and written evidence, including any new or additional evidence or consultation and any closing statements or summary made after conclusion of the hearing as directed by the Presiding Officer or Hearing Panel Chairperson, the hearing shall be closed.

5.D.3. Deliberations and Recommendation of the Judicial Review Committee

Within thirty (30) days after final closing of the hearing, the Judicial Review Committee shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report setting forth separately each charge against the Petitioner or Allied Health Professional, which report shall contain a summary of the evidence that supports or rebuts the charges, its findings on each fact in question and a concise statement of the reasons for its recommendation. Such report shall contain the Judicial Review Committee findings and recommendations.


Within twenty (20) days after conclusion of such deliberations the Judicial Review Committee shall deliver its report, together with the hearing record and all other documentation considered by it, to the CEO who shall forward it, along with all such supporting documentation, to the Board of Directors if its adverse action or recommendation prompted the hearing, or to the Medical Executive Committee, if such committee’s action or recommendation prompted the hearing, for further action.


The Medical Executive Committee or the Board of Directors, as the case may be as provided in Section 5.D.4., at its next regularly scheduled meeting (but not later than forty-five (45) days after receipt of the report of the Judicial Review Committee), shall consider the same and affirm, modify or reverse its previous recommendation or action in the matter. It shall transmit notice of its action and the basis for its action, together with the hearing record, the report of the Judicial Review Committee and all other documentation considered, to the CEO.

5.D.6. Notice and Effect of Results

(a) Effect of Favorable Result

(1) Adopted by the Medical Executive Committee: If the Medical Executive Committee’s findings pursuant to Section 5.D.5 are favorable to the Practitioner or Allied Health Professional, the CEO shall promptly forward such findings, together with all supporting documentation, to the Board of Directors for its decision. The Board of Directors shall take action thereon by adopting or rejecting the Medical Executive Committee’s recommendation in whole or in part, or by referring the matter back to the Medical Executive Committee for further
reconsideration. Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board of Directors must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Directors shall take final action. The CEO shall promptly send the Practitioner or Allied Health Professional Special Notice informing the Practitioner or Allied Health Professional of each action taken pursuant to this subparagraph (1) and his/her right to request a copy of the recommendation of the Medical Executive Committee and the Board of Directors.

Favorable action shall become the final decision of the Board of Directors, and the matter shall be considered finally closed. If the Board of Directors’ action is adverse in any of the respects listed in Section 5.A.1 (except as provided in Section 5.A.3), the Special Notice required by subparagraph (c) of this Section 5.D.6 shall inform the Practitioner or Allied Health Professional of his/her right to request an appellate review by the Board of Directors as provided in Section 5.E.

(2) **Adopted by the Board of Directors:** If the Board of Directors is the body whose action or recommendation prompted the hearing and thus is considering the recommendation of the Judicial Review Committee, it shall take action thereon by adopting or rejecting the Judicial Review Committee’s recommendation in whole or in part, or by referring the matter back to the Judicial Review Committee for further reconsideration. Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board of Directors must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Directors shall take final action. If the Board of Directors’ action pursuant to Section 5.D.5 is favorable to the Practitioner or Allied Health Professional, such result shall become the final decision of the Board and the matter shall be considered finally closed. The Practitioner or Allied Health Professional shall be so notified of the action taken and of the Practitioner’s or Allied Health Professional’s right to request a statement of the basis for the decision.

**Effect of Adverse Result**

If the action of the Medical Executive Committee or of the Board of Directors pursuant to subparagraph (a) continues to be adverse to the Practitioner or Allied Health Professional in any of the respects listed in Section 5.A.1 (except as provided in Section 5.A.3), the Special Notice required by Section 5.D.6(c) shall inform the Practitioner or Allied Health Professional of his/her right to request an appellate review by the Board of Directors as provided in Section 5.E.
(c) Notice of Result

The CEO shall promptly advise the Practitioner or Allied Health Professional by Special Notice of the action taken pursuant to Section 5.D.5 by the Medical Executive Committee or the Board of Directors, as the case may be, and shall also advise the President of the Medical Staff and the Board of Directors, if such action was of the Medical Executive Committee. The Practitioner or Allied Health Professional shall be furnished, upon request, a copy of the written recommendation of the Medical Executive Committee or the Board of Directors and of the Judicial Review Committee and the basis for the Judicial Review Committee’s recommendation. The notice shall also advise the Practitioner or Allied Health Professional of his/her right to request an appellate review, by the Board of Directors as provided in Section 5.E.

5.E. INITIATION AND PREREQUISITES OF APPELLATE REVIEW

5.E.1. Request for Appellate Review

A Practitioner or Allied Health Professional shall have ten (10) days following his/her receipt of the notice pursuant to Section 5.D.6(c) to file a written request for an appellate review. Such request shall be in writing delivered to the CEO either in person or by certified or registered mail, shall include a brief statement of the basis or reasons for appeal and may include, if desired, a request for a copy of the report and record of the Judicial Review Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or finding.

5.E.2. Grounds for Appeal

The grounds for appeal shall be as follows:

(a) there was substantial failure to comply with this Policy and/or the Bylaws in the matter which was the subject of the hearing so as to deny due process or a fair hearing; or

(b) the recommendations were made arbitrarily, unreasonably, or capriciously; or

(c) the recommendations were not supported by any rational basis.

5.E.3. Waiver by Failure to Request Appellate Review

A Practitioner or Allied Health Professional who fails to request an appellate review within the time and manner specified in Section 5.E.1 shall be deemed to have waived any right to such review. If an appellate review is not requested as provided in Section 5.E.1, such failure shall be deemed to be an acceptance of the recommendation or action involved, which action shall become effective immediately upon final Board of Directors action.
5.E.4. Notice of Time and Place for Appellate Review

Whenever an appellate review is timely requested in the manner set forth in the preceding sections, the CEO shall deliver such request to the President of the Board of Directors. Within thirty (30) days after receipt of such request, the President of the Board of Directors shall schedule and arrange for an appellate review which shall be scheduled not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the appellate review request from the Practitioner or Allied Health Professional; provided, however, that an appellate review for a Practitioner or Allied Health Professional who is under suspension then in effect, if requested by the Practitioner or Allied Health Professional, shall be held as soon as the arrangements for it may reasonably be made, but not later than thirty (30) days from the date of receipt of the request for review from the Practitioner or Allied Health Professional. Not later than fifteen (15) days, seven (7) days when the action involves a suspension then in effect if an expedited review is requested, prior to the scheduled date for the appellate review, the CEO shall send the Practitioner or Allied Health Professional Special Notice of the date, place and time of the review. The time for the appellate review may be extended by the Appellate Review Body or Board of Directors for good cause.

5.E.5. Composition of Appellate Review Body

The appellate review shall be conducted by an appellate review committee (the “Appellate Review Body”) composed of not less than 3 nor more than 7 persons, who may be members of the Board of Directors or such other persons, including but not limited to reputable persons outside the Hospital, appointed by the President of the Board of Directors to consider the record upon which the recommendation before it was made. One of the committee members shall be designated as Chairperson.


(a) The proceedings by the Appellate Review Body shall be in the nature of an appellate review based on its examination of the record of the hearing before the Judicial Review Committee or Hearing Officer, including their report, and all subsequent results and actions thereon to consider whether the hearing was fair and whether the recommendation of the Judicial Review Committee or Hearing Officer (and any subsequent recommendation of the Medical Executive Committee) was reasonable and supported by the record. The Appellate Review Body shall also consider the written statements submitted pursuant to subsection (c) of this Section 5.E.6 and such other materials as may be presented and accepted under subsections (b) and (d) of this Section 5.E.6.

(b) New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only for good cause shown. The Appellate Review Body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted. The Appellate Review Body may, but shall not be obligated to, accept such additional oral or written evidence, subject
to the same rights of cross-examination or confrontation provided at the Judicial Review Committee proceedings, as it may determine to be appropriate or helpful, in its sole discretion.

(c) Each party shall have the right to present a written statement in support of its position on appeal, provided that such statement is submitted to the Appellate Review Body through the CEO, at least fifteen (15) days prior to the date of the appellate review, unless otherwise provided by the Appellate Review Body. The CEO shall provide a copy of each submitted written statement to the opposing party at least ten (10) days prior to the date of the appellate review. If the matter is referred back to the Medical Executive Committee for further review and recommendation, the Medical Executive Committee shall promptly conduct its review and make its recommendations to the Appellate Review Body in accordance with the instructions given by the Appellate Review Body. This further review process shall in no event exceed thirty (30) days in duration, except as the parties may otherwise stipulate.

(d) The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

(e) The Chairperson of the Appellate Review Body shall be the presiding officer. He/she shall determine the order and procedure during the review, make all required rulings, and maintain decorum.

(f) The Appellate Review Body shall have all powers granted to the Judicial Review Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

(g) The Appellate Review Body may recess and review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, and the receipt of additional evidence or consultation, if requested by the Appellate Review Body, the appellate review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned except in the event of referral back to the Judicial Review Committee or the Medical Executive Committee as provided in Section 5.E.6 hereof. Unless so referred back to the Judicial Review Committee or other body, the Appellate Review Body will make its recommendation to the Board of Directors within thirty (30) days of its final conclusion of its review.
5.E.7. Action Taken

(a) The Appellate Review Body may recommend that the Board of Directors affirm, modify or reverse the adverse result or action taken by the Medical Executive Committee or by the Board of Directors, as applicable, pursuant to Section 5.D.5 or Section 5.D.6(b), or, in its discretion, may refer the matter back to the Medical Executive Committee or Judicial Review Committee for further review and recommendation to be returned to it within forty-five (45) days and in accordance with its instructions. Within thirty (30) days after receipt of such further recommendation after referral, the Appellate Review Body shall make its recommendation to the Board as provided in this Section 5.E.

(b) The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 5.E have been completed or waived.

5.E.8. Board of Directors’ Action

(a) Initial Action:

Within forty-five (45) days after the conclusion of the appellate review, the Board of Directors shall render its decision in the matter in writing and shall send notice thereof to the Practitioner or Allied Health Professional by Special Notice, to the President of the Medical Staff, and to the Medical Executive Committee. The Board of Directors may affirm, modify or reverse the recommendation of the Appellate Review Body or, in its discretion, refer the matter for further review and recommendation. If its decision is in accord with the last recommendation of the Medical Executive Committee in the matter, if any, it shall be immediately effective and final. If the Board of Directors’ action has the effect of changing the last recommendation of the Medical Executive Committee, if any, the Board of Directors shall refer the matter to a Joint Conference Review Committee as provided in subparagraph (b) of this Section 5.E.8.

(b) Joint Conference Review Committee:

The Joint Conference Review Committee shall consist of equal numbers of members of the Medical Staff and Board of Directors who shall be appointed by the President of the Board of Directors after consultation with the President of the Medical Staff. One of its members shall be designated as Chairperson. Within twenty (20) days of its receipt of a matter referred to it by the Board of Directors pursuant to Section 5.B.3.(b) or Section 5.E.7.(a) the Joint Conference Review Committee shall convene to consider the matter and shall submit its recommendation in writing to the Board of Directors no later than thirty (30) days thereafter.

(c) Final Board of Directors Action:

In the event the Board of Directors has referred the matter to the Joint Conference Review Committee pursuant to either Section 5.B.3.(b) or Section 5.E.7.(b), the
Board of Directors, within forty-five (45) days after receipt of the Joint Conference Review Committee’s recommendation, shall render its final decision. The Board of Directors’ action on the matter following receipt of the Joint Conference Review Committee’s recommendation, if applicable, shall be immediately effective and final.

5.F. GENERAL PROVISIONS

5.F.1. Further Review

The final decision of the Board of Directors following an appeal shall become effective immediately and shall not be subject to further review.

5.F.2. Right to One Appeal Only

No applicant, Medical Staff Member or Allied Health Professional shall be entitled to more than one appellate review on any matter which may be the subject of an appeal.

5.F.3. Ability to Reapply for Privileges

If the Board of Directors determines to deny initial Medical Staff appointment to an applicant, granting of Clinical Privileges to an Allied Health Professional or reappointment to a Member, or to revoke or terminate the Medical Staff appointment and/or Clinical Privileges of a current Member or Allied Health Professional, that Practitioner or Allied Health Professional may not apply for Medical Staff appointment or for those Clinical Privileges, as applicable, at the Hospital for a period of 3 years unless the Board provides otherwise.

5.F.4. Waiver

If at any time after receipt of a Special Notice of an adverse recommendation, action or result, a Practitioner or Allied Health Professional fails to make a required request or appearance or otherwise fails to comply with this Article, he or she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he or she might otherwise have been entitled under the Bylaws then in effect or under this Policy then in effect with respect to the matter involved.

5.F.5. Exhaustion of Administrative Remedies.

By applying for appointment to the Medical Staff or for Clinical Privileges or Scope of Practices, each applicant, Medical Staff Member and Allied Health Professional agrees that, in the event of any adverse adverse action or decision with respect to Medical Staff appointment, Department affiliation, and/or Privileges or Scopes of Practices, the applicant, Medical Staff member and Allied Health Professional shall exhaust the administrative remedies afforded by this Article before resorting to formal legal action.
ARTICLE 6

IMMUNITY AND INDEMNITY

6.A. IMMUNITY FROM LIABILITY

6.A.1. For Action Taken

Each representative of the Medical Staff and the Hospital shall be exempt, and have absolute immunity to the fullest extent permitted by law, from liability to the Practitioner, Member or Allied Health Professional for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a representative of the Medical Staff or the Hospital, their committees, members, agents, employees, advisors, counselors, consultants, attorneys, or any other person providing services to or through the Medical Staff, Hospital, or committee in conjunction with evaluation of a Practitioner, Member, or Allied Health Professional.

6.A.2. For Providing Information

Each representative of the Medical Staff, the Hospital, and all third parties shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner, Member or Allied Health Professional for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person.


The immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare facility’s or organization’s activities concerning, but not limited to:

(a) applicants for appointment, reappointment, or Clinical Privileges;

(b) corrective action;

(c) hearing and appellate reviews;

(d) utilization review, and

(e) other Department, Section, committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

6.A.4. Releases

Each applicant, Allied Health Professional or Member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.
6.A.5. Cumulative Effect

The provisions in this Policy and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to all other protections provided by law and not in limitation thereof.

6.B. INDEMNITY

All Medical Staff officers, Department Chairpersons, committee Chairpersons, committee members and specially appointed individual Members who act, in good faith, for and on behalf of the Hospital in discharging their Hospital responsibilities and professional review activities, including quality improvement and utilization review activities, pursuant to this Policy or the Bylaws shall be indemnified, to the fullest extent permitted by law, upon approval of the appointment and/or election of such Members by the Board of Directors.

ARTICLE 7
AMENDMENTS

7.A. ULTIMATE AUTHORITY OF BOARD OF DIRECTORS

The Board of Directors has the ultimate duty and responsibility for appointments to the Medical Staff. The Board respects the advice of the Medical Staff, however, as to the matters which are the subject of this Policy and therefore all amendments shall first be submitted to the Bylaws and Medical Executive Committees for review and comment at least thirty (30) days prior to any final action by the Board of Directors on such amendment. Notwithstanding the foregoing, the Board of Directors may amend this Policy without prior consultation with the Bylaws Committee or Medical Executive Committee where such amendments are deemed necessary by the Board of Directors:

(1) to comply with changes in federal and state laws that affect the Hospital or any parent corporation thereof, including any of their entities and the failure to take immediate action would adversely affect the Hospital;

(2) to comply with state licensure requirements, Joint Commission Accreditation Standards, and Medicare/Medicaid Conditions of Participation for Hospitals or other agency regulations and the failure to take immediate action would adversely affect the Hospital; and

(3) To correct clerical errors or omissions, or make technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression.
7.B. AMENDMENT UPON REQUEST OF BYLAWS OR MEDICAL EXECUTIVE COMMITTEE

This Policy may also be amended by the Board of Directors upon written request initiated from the Bylaws Committee of the Medical Staff or Medical Executive Committee setting forth the requested amendment and reasons therefor and approval by the Board of Directors. The Board of Directors shall not adopt any such recommended amendment without first having submitted it to the Medical Executive Committee for review and comment at least thirty (30) days prior to any final action by the Board on such amendment, except as provided in the preceding Section 7.A.

ARTICLE 8

ADOPTION

This Policy is adopted and made effective upon approval of the Board of Directors, superseding and replacing all prior Bylaws, provisions or similar appointment policies pertaining to the subject matter thereof, and henceforth all activities and actions of the Medical Staff and of each individual seeking Medical Staff appointment, the granting of or exercising of Clinical Privileges at the Hospital shall be taken under and pursuant to the requirements of this Policy.

Date: September 20, 2013
Jeffrey Johnson, MD
President of the Medical Staff

Date: September 20, 2013
Lionel Tapia, MD
President-elect of the Medical Staff

This Appointment Policy is hereby approved by the Board of Directors of St. Vincent Healthcare.

Date: September 20, 2013
Jason Barker
President/CEO, St. Vincent Healthcare