

**RULES AND REGULATIONS
OF THE
PROFESSIONAL STAFF
OF THE
PROVIDENCE VALDEZ MEDICAL CENTER**

Revised: 03/2012

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RULES AND PROCEDURES
OF THE
PROFESSIONAL STAFF
PROVIDENCE VALDEZ MEDICAL CENTER

Article I. DEFINITIONS

1. "Administrator" or "Chief Executive" means the individual(s) appointed/employed by Providence Health & Services - Washington to act on its behalf in the overall management of the Hospital.
2. The term "The Board" means the board of directors responsible for conducting the affairs of Providence Health & Services –Washington ("PH&S-W"), which for purposes of these Bylaws and, except as the context otherwise requires, shall be deemed to act through the authorized actions of the Providence Health & Services Alaska ("PH&SA") Region Board, the officers of the corporation and through the Administrator of Providence Valdez Medical Center. .
3. "Committee" means a committee of the Professional Staff as established by the joint action of the Medical Executive Committee.
4. "Hospital" means Providence Valdez Medical Center.
5. "Credentials Committee" or "CC" means the committee responsible for Hospital credentialing and privileging.
6. "Medical Executive Committee" or "MEC" means the Medical Executive Committee of the Hospital.
7. "Member" means a Member of the Professional Staff appointed to and maintaining membership in a category of the Professional Staff, in accordance with the Rules and Regulations.
8. "Rules" mean the Rules and Regulations of the Professional Staff.
10. "The Professional Staff of Providence Valdez Medical Center-, " or "Professional Staff" means the medical physicians, osteopathic physicians, licensed oral and maxillofacial surgeons, dentists, podiatrists, clinical psychologists and certified nurse anesthetists who are granted membership and privileges to practice at the Hospital.

11. “Days” means calendar days.
12. “Practitioner” means a licensed healthcare provider.
13. “Applicant” means a Practitioner who makes an application for Professional Staff membership.
14. ENPC – Emergency Nursing Pediatric Care
15. TNCC – Trauma Nursing Core Curriculum
16. ACLS – Advanced Cardiac Life Support
17. PALS – Pediatric Advanced Life Support

Article II. MEMBERS OF THE PROFESSIONAL STAFF

Members of the Professional Staff are psychologists, dentists, physicians and podiatrists.

Section 1 Psychologist

Psychologist means a Practitioner licensed under AS 08.86 by the Alaska State Board of Psychologists and Psychologist Associates.

Section 2. Dentist

Dentist means a Practitioner licensed under AS 08.36 by the Alaska State Board of Dental Examiners.

Section 3. Physician

Physician means a practitioner with a M.D. or D.O. degree licensed under AS 08.64 by the Alaska State Medical Board..

Section 4 Podiatrist

Podiatrist means a practitioner licensed under AS 08.64.209 by the Alaska State Medical Board .

Article III. CATEGORIES OF THE PROFESSIONAL STAFF

The categories of the Professional Staff are Active, Active Provisional, Courtesy, Consulting, and, Affiliate. Request for category changes will be accepted no more than once per year except by written petition to and recommendation of the CC.

Section 1. Active

- A. Qualifications. The Active category shall consist of those Members who (a) have served as Active Provisional Members for the period of time necessary to demonstrate that they meet the eligibility requirements for advancement to Active status, and (b) choose to seek such advancement. Active Members must meet the general qualifications set forth in Article V, Section 1 of these Rules.
- B. Responsibilities. Active Members shall assume all the functions and responsibilities of membership in the Active category including the following: (1) caring for unassigned patients, emergency service care as determined by the appropriate committee, consultation as determined by the appropriate committee and approved by the MEC; (2) serving on Professional Staff committees, as assigned; (3) serving as Chair of Professional Staff Committees, as assigned; and (4) participating in quality assessment and monitoring activities, including evaluating Active Provisional Members, as assigned by Committee Chairs. In addition, Active Members are expected to attend Professional Staff Committee meetings as assigned.

Members of the Active category shall be entitled to vote in Committee meetings, General Staff meetings and shall be eligible to hold office.

- C. Criteria for Achieving and Maintaining Active Category Status: To achieve and maintain Active category status, each Member must demonstrate compliance with all of the following:
 - 1) Serve on appropriate hospital professional staff committees;
 - 2) Reasonable participation as requested in the quality review, risk management and utilization management activities of the Hospital as may be required of the professional staff;
 - 3) Satisfy the meeting attendance and special appearance requirement as found in these Rules;
 - 4) Upon request, serve in a reasonable rotational manner on the Emergency Room Call List. When on call, the Active staff member must be available within a reasonable time as per Emergency Department Policy to examine a patient to determine whether the patient has an emergency medical condition, or provide treatment, within the capabilities of the hospital, necessary to stabilize a patient who has an emergency medical condition.

A Member may not be eligible for Active status until he/she has served on the Active Provisional Professional Staff for a 6 to 12-month period.

Section 2. Active Provisional Members

- A. Qualifications. Active Provisional Members must meet the general qualifications set forth in Article V, Section 1 of these Rules. The Active Provisional category shall consist of Members being considered for the Active category. The evaluation and recommendation of the CC and approval by the MEC is required for advancement to the Active Staff.
- B. Responsibilities. Members of the Active Provisional category shall assume the following functions and responsibilities including: (1) caring for unassigned patients, emergency service care as determined by the appropriate committee, consultation as determined by the appropriate committee and approved by the MEC; (2) serving on Professional Staff committees, as assigned, but not in the capacity of Chair; (3) participating in quality assessment and monitoring activities, as assigned by Committee Chairs. In addition, Members of the Active Provisional category are expected to attend General Professional Staff and Committee meetings. Members of the Active Provisional category shall be entitled to vote in Committee meetings, and at the General Staff meeting, but shall be ineligible to hold office.

Section 3. Courtesy

- A. Qualifications. Courtesy Members must meet the general qualifications set forth in Article V, Section 1 (General Qualifications) of these Rules. A Member of the Courtesy category may submit an application for the Active category at any time after the Member determines that he/she meets the eligibility requirements. The evaluation and recommendation of the CC is required.
- B. Responsibilities. Courtesy Members may be required to assume responsibility for the following: (1) care for unassigned patients, emergency service care as determined by appropriate committee and approved by the MEC. Members of the Courtesy category shall have no required Committee responsibilities, may not vote or hold office. Members of the Courtesy category are encouraged to attend Professional Staff and Committee meetings.

Section 4. Consulting

- A. Qualifications. Consulting Members must meet the general qualifications set forth in Article V, Section 1, (General Qualifications) of these Rules and shall consist of physicians who are of recognized professional ability and expertise who provide a service that is not available from a Member of the Active Staff; have been specifically invited by the MEC and the Board to apply for Consulting Staff status; provide services at the Hospital only at the request of Members of the Professional Staff; are members in good standing of the active staff at another accredited hospital (unless this requirement is waived by the Board after considering the recommendations of the CC and the MEC); and at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).
- B. Responsibilities: Consulting Staff members may evaluate and treat (but not admit) patients in conjunction with members of the Professional Staff; may exchange information from one site to another via electronic communications for the health and education of a patient or health care provider and for the purpose of improving patient care, treatment, and services, otherwise known as practicing telemedicine; are excused from providing call coverage for the Emergency Department and providing care for unassigned patients unless the MEC determines otherwise after reviewing the facts and circumstances and the needs of the Emergency Services.

Section 5. Affiliate

- A. Qualifications. The Affiliate Category shall consist of those Members who meet the general qualifications set forth in Article V, Section 1, (General Qualifications) of these Rules; have a hospital practice, but do not have admitting privileges due to their professional licensure, or who do not have a hospital practice but who wish to be associated with the Professional Staff for purposes of continuing education, collegial association and/or to establish and maintain a referral network.
- B. Responsibilities. Affiliate Staff shall be entitled to attend meetings, may serve on committees as assigned, but may not vote or hold office. Affiliate Staff shall have delineated clinical privileges as set forth in these Rules.

Article IV. INACTIVE STATUS

Members may be placed on Inactive status when a temporary absence from practice in the is expected due to prolonged illness, military service, sabbatical leave, office practice change, or other valid conditions. The Member can be upgraded to one of the four Professional Staff categories within two years from the date of placement on inactive status by satisfactorily completing the reappointment process. After two years, Professional Staff membership will automatically terminate without a right of appeal or fair hearing.

Article V. MEMBERSHIP

Section 1. General Qualifications

Every applicant who seeks, or is granted, Professional Staff membership must continuously demonstrate to the satisfaction of the Professional Staff and the Board the following qualifications:

- A. Licensure: Provide patient care services within the limits of his/her valid, current license issued by the State of Alaska and within his/her professional skills and abilities.
- B. Education: Graduate of an accredited school of medicine, or applicable professional school, and successful completion of an approved residency program or equivalent Independent Health Professional (IHP) training. Physicians and podiatrists shall be board certified or board admissible. If board admissible, the Member must become board certified within 5 years of completion of residency. Board certification must be maintained through recertification if required by Member's specialty board to

retain Professional Staff membership. This applies to all new applicants as of the date of these Rules.

Waiver:

- A. The purpose of the requirement of board certification is to ensure high quality practitioners. A waiver of this requirement may be granted if the applicant for medical staff membership and clinical privileges can document activities or experiences demonstrating the high quality of the practitioner. Such waiver shall be a separate consideration by the medical staff committee of the whole in the application process..
- C. Competence: Professional education, training, experience and documentation of current clinical activity demonstrating ability to provide quality patient services and perform the clinical privileges requested.
- D. Disability: Freedom from any physical, psychological or behavioral impairment that would prevent the Member from performing the essential functions of Member's specialty practice and the clinical privileges requested with reasonable accommodation.
- E. Cooperation and Ethical Relationship: A willingness and capability based on current attitude and documented performance to:
 - 1. Work with and relate to other Members, Hospital management, employees, patients, visitors and the community in a cooperative, professional manner;
 - 2. Discharge Professional Staff obligations appropriate to Member's category;
 - 3. Maintain professional conduct in accordance with the code of ethics for the Member's profession;
 - 4. Respect the fact that the Hospital is a Catholic institution and will be administered in accordance with the Providence Health System Mission and Core Values and the Roman Catholic moral tradition as articulated in such documents as the Ethical and Religious Directives for Catholic Health Care Services. Medical conduct or procedures within the hospital will be consistent with said Mission and Values and moral tradition.
 - 5. Care for patients regardless of disease status within the scope of Member qualification, competency and privileges.
 - 6. Members shall comply with Providence Health & Services Code of Conduct and Providence Health & Services Alaska and Region Policies that pertain to the Professional Staff, some of which are listed as Exhibit A to these Rules.

Copies of Hospital policies shall be available in the Medical Staff Office upon request.

- F. Confidentiality: The confidentiality of protected health information (any information, including demographic information that can be used to identify the patient) and any other patient, physician, medical, financial information, whether paper, oral, or electronic is an obligation of all Members. This information shall not be released to any individual, organization or agency without proper authorization. Inappropriate or indiscriminate release of this information is a serious breach of privacy with possible legal and criminal sanctions. All information regarding patients, physician and/or their practices is confidential. No Member shall have access to, or the right to review paper or electronic patient records or to disclose this information except when necessary to provide treatment, protected peer review activities, or payment activities.
- G. Medicare/Medicaid Participation: At all times the Member will maintain eligibility and qualify for participation in the Medicare and Medicaid programs.
- H. Non-Physician Members: Non-physician with appropriate licensure may be granted membership in the Professional Staff and are referred to in the By-laws and these Rules as "Non-Physician Members". Non-physician members include licensed health care professionals, who provide independent patient care within the limits of the professional skills and abilities, and shall include but not necessarily be limited to: doctors of psychology, podiatrists, dentists and certified registered nurse anesthetists. The degree of participation of Non-Physician Members in patient care shall be determined according to privileges approved by the Board and may require a supervisory, consulting or other collaborative relationship with other members of the Professional Staff as delineated in the course of their privileging. Non-physician Members must have the ability to meet Medicare/Medicaid conditions of participation and JCAHO standards, and conditions of reimbursement to the Hospital for services.
 - 1. Specialties
 - a) Clinical Psychologists: A clinical psychologist with clinical privileges may participate in patient care and perform psychological testing, evaluation, counseling or other activities within the scope of his/her clinical privileges. Clinical psychologists may not admit patients or write orders. A physician Member must admit the patient and be responsible for the care of the patient during hospitalization.
 - b) Dentists: The patient of a dentist with clinical privileges may, with the concurrence of an appropriate physician Member, be admitted to the Hospital. The concurring physician Member shall assume responsibility

for the overall aspects of the patient's care throughout the Hospital stay, including the medical history and physical examination. Dentists are responsible for the part of the patient's history and physical examination that relates to the practice of dentistry.

- c) Podiatry: The patient of a podiatrist with clinical privileges may, with the concurrence of an appropriate physician Member, be admitted to the Hospital. The concurring physician Member shall assume responsibility for the overall aspects of the patient's care throughout the Hospital stay, including the medical history and physical (H&P) examination. Podiatrists are responsible for the part of the patient's history and physical examination that relates to the practice of podiatry. Podiatrists may be granted clinical privileges to perform admission history and physical examinations if they document compliance with the appropriate training requirements as established by the Board.
- d) Certified Registered Nurse Anesthetist: CRNAs will provide independent patient care within the limits of their professional skills and ability and as determined according to privileges recommended to and approved by the Board.

Section 2. Professional Staff Application Fees and Dues

- A. An application fee, reappointment fee and annual Professional Staff dues, as approved by the MEC, will be set if required for all applicants and Members.

Section 3. Professional Liability Insurance

Members shall continuously maintain and provide written evidence to the Medical Staff Office of professional liability insurance with minimum limits of at least \$1 million per occurrence and \$3 million in the aggregate. Applicants to the Professional Staff shall furnish evidence of insurance coverage with the application for membership; and by Members at reappointment. A Member shall notify the Medical Staff Office in writing of termination or change of insurance coverage within one week of receiving notice of such termination or change. The insurance coverage requirement may be modified or waived by the MEC for Affiliate Staff without admitting or clinical privileges on an individual basis.

Section 4. Organized Health Care Arrangement Policy (OHCA) Health Insurance Portability and Accountability Act (HIPAA)

- A. Organized Health Care Arrangement. In order to facilitate the disclosure of protected health information between Providence Health & Services, Alaska Region facilities, services and programs under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Region has established an Organized

Health Care Arrangement under 45 CFR 164.501 ("Providence OHCA"). All Alaska facilities, services and programs, Providence employees, and practitioners and other clinicians who are members of the Professional Staff and/or who otherwise have Professional Staff privileges at Hospital's facilities, services or programs have been invited to participate in the Providence OHCA. The Professional Staff, through this Policy, has accepted the invitation to participate in the Providence OHCA. Under the Providence OHCA, all of the members, including members of the Professional Staff, may rely on a Joint Notice of Privacy Practice and Acknowledgment. Further, members of the Providence OHCA may use and disclose protected health information in the conduct of their joint operations and joint activities, all in a manner consistent with the requirements of HIPAA.

- B. Notice of Privacy Practices. Each Member shall be required to use and conform to the terms of the Joint Notice of Privacy Practice developed and used by the Region with respect to protected health information created or received as part of each Member's participation in the Providence OHCA and to comply with all applicable Providence, Professional Staff and HIPAA requirements, policies and procedures relating to the confidentiality of protected health information.

Each Member is responsible for his/her own compliance with applicable state and federal laws relating to protected health information. The establishment of the Providence OHCA shall not in any way create additional liabilities by or among the members of the Providence OHCA or cause one or more Providence OHCA members to assume responsibilities for the acts or omissions of any other member of the Providence OHCA, and each member of the Providence OHCA shall be individually responsible for his/her/its own acts or omissions with respect to compliance with HIPAA requirements.

The MEC may establish from time to time such additional rules and requirements to assure conformity with the above requirements, including requiring each Member at the time of his/her initial appointment and any subsequent reappointment, to sign and acknowledge his/her individual responsibilities with respect to the above requirements.

Article VI. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Objectives

- A. To assist in fulfilling the responsibility of the Professional Staff to assure that Practitioners permitted to provide patient services independently in the Hospital are granted clinical privileges consistent with their individual training, experience, current competency and other qualifications;

- B. To assure that each eligible Applicant is afforded equal opportunity to be appointed or reappointed to the Professional Staff;
- C. To assure that adequate information pertaining to education, training, relevant experience, and current competency is reviewed by the appropriate individuals and committees prior to rendering a recommendation to the Board or its designee.

Section 2. Conditions and Duration of Appointments

Active members shall be required to have an office and residence within 45 minutes access to the Hospital in order to hold clinical privileges. Members must be available within 30 minutes when on emergency call. Courtesy members must be available within 30 minutes when they have responsibility for inpatients.

Initial appointments and all reappointments shall be for a period of no greater than two years.

Initial appointment, reappointment and/or the renewal or revision of clinical privileges is based on an appraisal of the Applicant at the time of appointment, reappointment and/or the renewal or revision of clinical privileges. The appraisal will include information concerning the following:

- A. Current licensure,
- B. Education, continuing education, training, and board certification,
- C. Current competence,
- D. Professional performance,
- E. Judgment,
- F. Clinical or technical skills, as indicated in part by the results of quality assessment and risk management activities,
- G. Health, as it relates to the ability to perform the clinical privileges requested,
- H. Any previously successful or pending challenge to any licensure or registration including the Drug Enforcement Agency ("DEA") hospital medical staff membership or clinical privileges, professional society membership or board certification, or the voluntary or involuntary relinquishment of such licensure or registration,
- I. Voluntary or involuntary termination of professional or medical staff membership, or voluntary or involuntary relinquishment, limitation, reduction, or loss of clinical privileges at another hospital,
- J. Professional liability actions including pending or final claims, judgments or settlements,
- K. Completeness and timeliness of medical records,
- L. Personal and professional ethics and conduct,
- M. Observance of Professional Staff Bylaws, Rules, and applicable Hospital policies,
- N. Medicare/Medicaid sanctions, and

Each applicant agrees to notify the Administrator promptly of the following: (1) any sanction, restriction, suspension, probation, termination or other change in licensure or participation in Medicare, Medicaid or other government programs, (2) any change in professional liability insurance coverage, (3) any sanction, restriction, denial or surrender of the practitioner's hospital privileges or professional or medical staff membership in another hospital, (4) any professional liability settlement or judgment, (5) any felony criminal conviction, (6) any conviction of drug or alcohol offense, (7) any entry or participation in a rehabilitation program, (8) any revocation, suspension or voluntary relinquishment of practitioner's license or DEA certificate, (9) any adverse determination by a medical professional review organization, or (10) the commencement of a formal investigation or the filing of charges by any federal or state agency against the Practitioner, unless such information is exempt from disclosure by law. In the event a practitioner is in a rehabilitation or diversion program, applicant agrees to report to the Administrator upon entering the program and on a quarterly basis thereafter. The Practitioner shall authorize the program to submit a written statement to the Administrator regarding the Practitioner's treatment.

Section 3. Nondiscrimination

No aspect of Professional Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color or national origin, or on the basis of any other criterion unrelated to the delivery of quality patient care at Hospital to professional qualifications, to the hospital purposes, needs and capabilities, or to community need.

Section 4. Application for Appointment

Eligible applicants desiring appointment to the Professional Staff shall complete and submit a Board approved application. Currently, the application is processed through a Credentials Verification Organization (CVO) for Professional Staff who are also members of Providence Alaska Medical Center and by Hospital for all local members. The CVO and/or the Hospital obtains all relevant documentation required in the application, including primary source verification where required. The application shall specify the category of Professional Staff appointment, clinical privileges requested and shall include primary source verifications as indicated by an asterisk (*):

- A. Licenses and registrations, current and previous*
- B. Board certifications*
- C. National Practitioner Data Bank query report*
- D. DEA certification, if applicable
- E. Documentation of current clinical competence*
- F. Military history
- G. Medical, IHP and other graduate education and training*
- H. Continuing medical education (CME), related, at least in part, to the privileges granted

- I. Professional society memberships
- J. Previous medical/clinical practice since completion of education/training*
- K. Hospital affiliations, current and past*
- L. Teaching appointments
- M. Liability insurance carrier for last five years, including current coverage limits*
- N. Malpractice claims history*
- O. History of adverse actions, including revocation, suspension, reduction, limitation, probation, non-renewal, voluntary or involuntary relinquishment, withdrawal or failure to proceed with an application, or other professional sanction for any of the following:
 - state medical license,
 - professional registration/license,
 - DEA/controlled substance registration,
 - academic appointment,
 - membership on any hospital medical staff or managed care organization,
 - clinical privileges at any other hospital,
 - prerogatives/rights on any medical staff,
 - other institutional affiliation or status threat,
 - professional society membership or board certification,
 - participation in Medicare, Medicaid or other government programs,
 - focused review required by PRO or similar regulatory agency,
 - current investigations and current or pending denials.
- P. Health status as it relates to privileges requested, with or without accommodations,
- Q. Professional peer references.*

Every application for Professional Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of his/her obligation to abide by the Professional Staff Bylaws, Rules and applicable Hospital policies. Active members shall agree to provide continuous care and supervision of their patients, including identification of similarly qualified individuals agreeing to provide call coverage. Courtesy members shall agree to provide similar coverage for their patients while in town. Consulting members shall agree to coverage as agreed to by contract.

Each Applicant agrees to appear for interviews in regard to this application as requested; authorizes the Board, Administrator, Professional Staff and their representatives to consult now and for the duration of their Professional Staff membership with physicians and others who may have information bearing on the Applicant's demonstrated current clinical competence, character and ethical qualifications, health status as it relates to the ability to perform the privileges requested, current licensure, relevant training and experience; and consents to inspection by the Board, Administrator, Professional Staff and their representatives of all records and documents that may be material to evaluating the Applicant's professional qualifications and competence to perform the clinical privileges requested and the applicant's moral and ethical qualifications for membership.

Release from Liability. The Applicant releases the Board, Administrator, Hospital, Professional Staff and their representatives from any liability for their acts performed, written or oral statements made in good faith and without malice, in connection with evaluating the Applicant, the Applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, and consents to the performance of such acts and making of such statements. The Applicant further agrees to release from any liability all individuals and organizations who provide information or make written or oral statements to the Board, Administrator, Hospital, Professional Staff or their representatives in good faith and without malice concerning the Applicant's competence, ethics, character and other qualifications for Professional Staff appointment and clinical privileges, including otherwise privileged or confidential information, and consents to the providing of such information and the making of such statements.

The Applicant shall further agree that all such consents, releases, authorizations and agreements made in connection with the application for initial appointment shall be fully applicable to all actions, statements, and information taken, made or provided by or to the Board, Administrator, Hospital, Professional Staff or their representatives in connection with reappointments, corrective action, hearings, appellate review and professional or other reviews or appraisals of whatever kind, as provided for in the Bylaws or by the Policies. The applicant further acknowledges the provision in the Bylaws for release and immunity from civil liability.

The Applicant shall attest to the correctness and completeness of all information furnished and agree that any material misstatement in, or omission from, the application may result in termination of the initial application or reappointment process, denial of appointment or summary dismissal from the Professional Staff.

Section 5. Appointment Process

A. **Complete Application.** A complete application is required, which includes:

- 1) a complete, signed application form with complete verification of information, (refer to Section 4)
- 2) a complete, signed request for privileges,
- 3) the required application fee if applicable;
- 4) other information as requested.

In the event any required information is not received, assistance may be requested from the Applicant. Failure of an Applicant to adequately respond to a request for assistance will, after thirty days, be deemed a voluntary withdrawal of the application. In the event any information provided by the Applicant varies

significantly from information obtained during the appointment process, the Applicant will be provided an opportunity to correct erroneous information.

- B. **Credentials Committee.** The CC member assigned to review the Applicant's file will make recommendations based on review of the complete application, and telephone contact with references, as deemed necessary. Further information may be requested from any of the references or from other sources.

The CC member will review the request for clinical privileges and make recommendations, including any conditions or comments. Clinical privilege recommendation shall refer to relevant training and experience, current competency, fulfillment of obligations in accordance with the Professional Staff Bylaws and the Policies and health status as it is applicable to the privileges requested.

The CC member will present the recommendation to the CC. The CC member may make one of the following recommendations to the CC:

- 1) Approval of membership and clinical privileges;
 - 2) Approval with conditions;
 - 3) Deferral and request for further information; including request for a special investigation or focused review (defined in Article VIII, Section 3).
 - 4) Denial of membership and/or clinical privileges
- C. **MEC.** The MEC reviews the CC's recommendations and makes recommendations to the Board. Information contained in the complete application shall not be more than 180 days old at the time of the MEC's review. The MEC's recommendations may include:
- 1) Approval of membership and clinical privileges;
 - 2) Approval with conditions;
 - 3) Deferral and request for further information;
 - 4) Denial of membership and/or clinical privileges.

If the MEC recommends denial of membership and/or clinical privileges less than those applied for, the Administrator acting for the Board shall, by certified mail, notify the applicant of the MEC's recommendation. The notice shall inform the applicant of his/her right to a hearing and shall be accompanied by a copy of the Bylaws and Policies.

The Applicant shall have 30 days from the date of the certified letter in which to file a request with the Administrator for a hearing pursuant to Article XI, page 8 (Fair Hearing Plan) of the Policies. If the applicant does not make a timely request for a hearing, the MEC's recommendation shall be forwarded to the Administrator. If the Applicant does request a hearing within the requisite period, the recommendation shall be stayed until a hearing is held and a final recommendation is forwarded to the Board.

D. **Board.** After receiving the recommendation of the MEC, the Board, acting through the Administrator, shall, within 30 days, make its determination as to the acceptance, deferral or denial of the application and the scope of clinical privileges to be granted. Under normal circumstances, determination will be made within 180 days of a complete application. The MEC shall provide such information as the Administrator may request. The Administrator shall send notice of determination to the Applicant. A denial of membership and/or clinical privileges will be sent by certified mail.

E. **Hospital Orientation.** All approved Applicants will receive at least the following orientation materials:

- 1) Information on the Mission of Providence Health & Services--;
- 2) General information regarding Hospital departments, safety, and medical records;
- 3) Professional Staff information regarding organization, continuing medical education opportunities, Member services and computer services;
- 4) Patient care procedures, services and programs;
- 5) Information on Alaska's Advance Directive law; and
- 6) Hospital policies pertinent to Members, e.g. verbal abuse, smoking, hostile and abusive patient, physician assisted suicide, and conscious sedation.

Section 6. Reappointment Process

Prior to expiration of a Member's appointment, the Hospital will initiate the reappointment process. Eligible Members desiring reappointment to the Professional Staff shall be subject to the same requirements and processes described in Section 4 (Application for Appointment) and Section 5 (Appointment Process) specific to the time period since the last appointment. Applicants for reappointment are not required to attend an Orientation meeting.

Applicants for reappointment must return the requested application, privilege forms and other information within 30 days. If the information is not received within 90 days it will be considered a voluntary resignation.

A. **Complete Application.** Additional information required for reappointment applications includes:

- 1) statistics showing clinical activity;
- 2) the Member's quality file containing results of QA case review, focused studies, monitoring reports, drug use evaluations, complaints, incident reports, patient survey responses, correspondence regarding concerns, corrective or disciplinary actions and medical record delinquencies and suspensions.

Article VII. CLINICAL PRIVILEGES

Section 1. Granting and Maintaining Clinical Privileges

Members shall be entitled to exercise only those clinical privileges delineated and specifically granted by the Board, acting through the Administrator, except as provided in Sections 2 and 3 of this Article.

- A. Appointment.** In the initial application for Professional Staff appointment, the Applicant must request specific clinical privileges and meet the established privileging criteria as delineated on the privilege form. Recommendations for clinical privileges will be based on the Applicant's evidence of meeting the established privileging criteria, education, training, experience, demonstrated current clinical competence, peer recommendations, health status as it impacts the privileges requested, and other relevant information. The Applicant shall have the burden of demonstrating qualification and competency for the clinical privileges requested.
- B. Reappointment.** Requests for clinical privileges at reappointment will be evaluated based on evidence of meeting the established privileging criteria as delineated on the privilege form, documented clinical activity, observation of care provided, conclusions drawn from performance improvement activities when available, in addition to the requirements of appointment as described above.
- C. Additions.** Members may apply for additional clinical privileges at any time. Such requests shall be submitted and processed in the same manner as the initial request. Temporary privileges may be granted after the Member has met the established privileging criteria and has been recommended by the CC.
- D. New.** If a Member requests a clinical privilege for which privileging guidelines have not been established, the Member is informed that the request cannot be processed until a determination is made that the procedure will be offered by the Hospital and privileging guidelines are established by the Board. Privileging guidelines are developed by a committee designated by the MEC and forwarded to the Board. This process will be completed as expeditiously as possible. Members granted privileges in new procedures are expected to assist in the training and proctoring of other Members.

- E. **Revisions.** The CC will review and make recommendations to the MEC and Board on all revisions to established privileging criteria.

Section 2. Temporary Privileges

Temporary clinical privileges are not routinely granted. Special requirements for supervision and reporting may be imposed by the Hospital or the CC Member on any Practitioner granted temporary privileges. Practitioners granted temporary privileges must sign a statement agreeing to abide by the Professional Staff Bylaws, Rules, and applicable Hospital policies and procedures, sign a confidentiality agreement, and to adhere to any requirements or restrictions applicable to temporary privileges.

Time-limited temporary privileges, not to exceed ninety (90) days, may be granted under the following conditions by the Administrator or designee, acting on behalf of the Board, and with the recommendation of the CC Chair and MEC President or respective designees. Temporary privilege requests and supporting documentation should be submitted at least seven days in advance.

- A. **Initial Application.** Temporary privileges may be granted to an Applicant for membership and clinical privileges with a substantially complete application, which reasonably supports a favorable determination. A substantially complete application would include verification of all licenses and registrations; board certifications; DEA certification (if applicable); National Practitioner Data Bank query report; recent clinical activity; medical and other graduate education and training; medical/clinical practice, hospital affiliations and liability insurance and malpractice claims history for the previous five years; at least two professional peer references; history of any adverse actions, and health status as it relates to privileges requested. Under no circumstances may temporary privileges be granted if the application is pending because Applicant has not responded to or provided requested information.
- B. **Specific Patient.** Temporary clinical privileges for the care of specific patients may be granted to a Practitioner who is not an applicant. Primary source verification must be obtained which reasonably supports a favorable determination. Such temporary privileges shall be restricted to the treatment of specific patients and at the request of and under the responsibility of an Active Member who is designated as the attending physician or primary surgeon.

Temporary privileges shall be restricted to the treatment of no more than two requests in any twelve-month period. Except under extenuating circumstances, temporary privileges will not be granted as the primary surgeon or admitting practitioner.

- C. **Specific Services.** Temporary privileges for time-limited, or patient-specific care, may be granted to a Practitioner who is requested to provide a consulting or educational

service by the President, or who possesses a unique expertise unavailable from the Professional Staff. Primary source verification must be obtained, which reasonably supports a favorable determination.

- D. Emergency Privileges in a Disaster.** Temporary privileges may be granted to practitioners in the event of an emerging incident event and as directed by the Incident Command Center. Emerging Incident Events include events that have potential to negatively impact the ability to provide services, such as, but not limited to, mass casualty incidents, earthquakes, bioterrorism, civil disturbance, fire, evacuation, hazardous material spill and/or utility failure. Primary source verification, which reasonably supports a favorable determination, must be obtained, as soon as possible, of valid, current license issued by the State of Alaska or completion of the Board of Medical Examiners out-of-state physician form or membership of the National Disaster Medical System (NDMS), photo identification, current professional liability insurance, and current hospital affiliations. In cases where the complete verification process cannot be accomplished immediately, the Administrator or designee may grant temporary privileges upon presentation of any of the following: current hospital photo identification card, current state medical license and a valid picture identification issued by a state, federal or regulatory agency, identification of membership in the NDMS, or presentation by current hospital staff or Professional Staff members with personal knowledge regarding the practitioner's identity. The practitioner will be paired with a Member. A processing fee for administration of temporary privileges will not be assessed.
- E. Locum Tenens.** Temporary admitting and clinical privileges may be granted to a Practitioner serving as a locum tenens for an Active Member. A completed, signed application approved by the CC is required and primary source verification must be obtained, which reasonably supports a favorable determination. A processing fee for administration of temporary privileges, as set by the MEC, will be assessed by the Hospital.
- F. Termination.** Temporary privileges may be terminated, reduced or modified on discovery of any information or occurrence of any event that places in question the Practitioner's professional qualifications, ethical standing, or clinical competence, or when the life or well-being of a patient is in danger. Temporary privileges in a disaster are terminated as directed by the Incident Command Center or at the conclusion of the emerging incident event. In the event of such termination, patients will be assigned to a Member by the Committee Chair or designee.

If temporary privileges are terminated, reduced or modified, the Practitioner will not be entitled to any of the procedural rights accorded to a Member. However, a Practitioner whose temporary privileges were terminated while in the initial application process for membership retains the rights afforded under these Rules.

Section 3. Emergency Privileges

An "emergency" is defined as a condition in which serious harm may result to a patient or in which the patient's life would be endangered by any delay in administering treatment. In the case of emergency, any Member with clinical privileges, to the degree permitted by license and regardless of Committee affiliation, status or clinical privileges, shall be permitted and expected to do everything possible to save the life of a patient or to save the patient from serious harm, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. Once the patient has been stabilized then a practitioner with the appropriate privileges will assume care.

Article VIII. CLINICAL OR PROFESSIONAL CONDUCT CONCERNS/CORRECTIVE ACTION PLAN

Section 1. Committee Chair Review and Recommendation

Issues of concern or written complaints regarding a Member's clinical or professional conduct are referred to the Committee Chair, or Board Chairman if the issue or concern relates to the Committee Chair, for review and to the CC Chair for information. The Committee Chair will review all pertinent documentation, including medical records, if appropriate. Sexual harassment or misconduct complaints received from a Hospital employee or regarding a Hospital employee will be addressed by the Department of Human Resources according to Hospital policy, with notification to Committee Chair.

Information may come to the Committee Chair from the following sources:

- a) Information that is collected routinely as part of the ongoing quality monitoring system;
- b) Information that is collected and analyzed as a result of studies specific to a diagnosis, procedure or Member;
- c) Information collected and analyzed as a result of a specific complaint or unusual occurrence report related to competence or professional conduct; and
- d) Information obtained from public sources or from a Member.

After the review is completed, documentation of the events, findings and conclusions is placed in the Member's Quality file with copies to the Committee Chair, CC. The conclusion may be a recommendation for:

- a) No further action;
- b) A documented informal discussion with the Member;

- c) A documented interview/special appearance (defined in Section 2);
- d) A focused review or investigation with documented findings (defined in Section 3); or
- e) Referral with recommendation to the CC for information and the MEC for review and possible action and to the CC for information.

Section 2. Interview/Special Appearance

The Member may be required to meet and confer with the Administrator, Chief of Staff or committee appointed to investigate the clinical or professional conduct concerns. The Member will be given written notice at least seven days in advance of the meeting. The notice will include the date, time and place of the meeting, a statement of the issue, that the Member's appearance is mandatory and failure to appear will result in automatic suspension. At this meeting, the Member will be invited to discuss the concern. This meeting is not a procedural right of the Member and need not be conducted according to the procedural rules provided in the Fair Hearing Plan. A written report is maintained in the Member's Quality file summarizing the events, findings and conclusions, with copies to the Administrator, Chief of Staff, CC and MEC. The conclusion may be a recommendation for:

- a) No further action;
- b) A focused review or investigation with documented findings (defined in Section 3); or
- c) Referral with recommendation to the MEC for review and possible action and to the CC for information.

Section 3. Focused Review or Investigation

If it is determined there are significant clinical or professional conduct concerns, a focused review or investigation may be initiated. Written notice will be provided to the Member regarding the scope of evaluation when a focused review is initiated. The Member will receive feedback of the focused review findings. A summary of the events, findings and conclusions will be placed in the Member's Quality file. The conclusion may be a recommendation for:

- a) No further action; or
- b) Referral with recommendation to the CC for information and MEC for review and possible action and to the CC for information.

Section 4. Review by MEC

The MEC may act on the recommendations or request a review by a committee of two or more Members or an outside reviewer designated by the Administrator. A review committee or outside reviewer shall not include partners, associates, competitors, or relatives of the Member.

A review committee may appoint an independent investigator, investigative panel or organization to assist in its review. Such investigator, panel or organization shall have the right to review all relevant documents and to interview persons with information relevant to the issue and the Member. The review committee or outside reviewer shall forward a report to the MEC for its review and possible disciplinary action.

Section 5. Action by MEC

Following completion of the investigation or evaluation by the MEC, the MEC's recommendations are forwarded to the CC for information. A summary of the events, findings and conclusions will be placed in the Member's Quality file, with a copy to the Committee Chair. The conclusion may be a recommendation to the Board for:

- a) No further action;
- b) A letter of admonition;
- c) Membership and/or clinical privileges to be suspended, modified, conditioned, or revoked; or
- d) other action.

Section 6. Action by Board

If the MEC's recommendation is for reduction or suspension of clinical privileges, for a requirement of consultation or other conditions, or for revocation or suspension of membership, the Administrator acting on behalf of the Board shall, by certified mail, notify the Member of the MEC's recommendation. The notice shall advise the Member of his/her right to a hearing pursuant to the Fair Hearing Plan and shall be accompanied by a copy of the Bylaws and the Rules. All further action will be in keeping with the Fair Hearing Plan (Article XI, page 8).

Section 7. Procedure 100 - Substance Abuse Policy

The following steps will be taken if a Member comes to the Hospital to provide patient care, and the Member's behavior or physical condition or appearance raises a reasonable likelihood that, due to the apparent influence of alcohol or drugs, (a) patient care or safety may be compromised, (b) Hospital operations may be disrupted, or (c) the community's confidence in the Hospital may be impaired. Examples of behavior, physical condition or

appearance that may give rise to implementing this policy are, without limitation, slurred or incoherent speech, uncharacteristic moodiness, undue aggressiveness or disruptive conduct, and/or lack of coordination in fine or gross motor skill, i.e., writing, walking, etc.

Anyone who observes behavior or a physical condition or appearance of a Member in the Hospital that raises a question of impairment by a Member while responsible for patient care should immediately notify the nursing supervisor. Upon receipt of a complaint, the nursing supervisor will notify the Chief of Staff or his/her designee such as a member of the MEC or the Assistant Chief of Staff. This person will be designated the Investigator and will proceed to the Hospital to investigate the complaint in accordance with Article VI of the Bylaws and Article VIII of the Rules. Awaiting the arrival of the Investigator, the Nursing Supervisor does have the prerogative to hand patient care by the Member over to another qualified Member, in accordance with Hospital guidelines. As part of the investigation, the Member and/or the Investigator may request appropriate lab tests to determine evidence of chemical impairment.

If, in the Investigator's opinion, the Member is considered to be impaired, alternative medical coverage for patients of the Member shall be arranged by the Investigator. The Member shall be directed to leave Hospital premises. If necessary, transportation safety for the Member will be addressed prior to departure.

The Investigator will provide documentation of the incident to the MEC. Documentation will include name of Member, date and time of the incident; name of patient(s) involved; individual reporting the incident and circumstances leading to Investigator's notification; specific complaint; Investigator's evaluations; Member designated to assume patient care responsibilities; transportation arrangements made for the impaired Member; and name(s) of any additional staff present.

A meeting to discuss the incident will occur within ten days. Participants will include the Member, Investigator, Chief of Staff (MEC) and others as determined necessary by these three. Documentation will remain in the Member's Quality file.

Upon receipt of a second complaint, the above process will be used except that the Investigator shall require appropriate lab testing of the Member and evaluation by an expert in substance abuse or other appropriate field (i.e., mental health). The investigation of a second complaint, including the results of lab testing and the results of the outside expert evaluator, shall be referred to the MEC in accordance with Article VIII, Section 4 of the Rules, for review and/or action by the MEC.

Article IX. SUMMMARY SUSPENSION

Section 1. Imposition

Whenever it is considered that action must be taken immediately in the interest of patient

care, health and/or safety of any individual or to the orderly operation of the Hospital, any two of the following: MEC Chief of Staff, Assistant Chief of Staff, or Administrator shall have authority to summarily suspend all or any portion of the clinical privileges of a Member. The summary suspension shall become effective immediately upon imposition. Notice of the summary suspension shall be promptly forwarded to the MEC, Administrator, appropriate Hospital departments, and by certified mail, to the Member. The summary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken but is not a complete professional review action in and of itself. It shall not imply any final finding or responsibility for the situation that caused the suspension.

Section 2. Action by MEC

Within seven days of a summary suspension, the MEC, shall recommend modification, continuance or termination of the terms of the summary suspension, and shall promptly notify the CC and the Administrator of its action. If the MEC recommends continuance or modification, the terms of the summary suspension as sustained or as modified shall remain in effect pending a decision by the Board, acting through the Administrator.

If the MEC does not recommend modification, continuance or termination within seven days of a summary suspension, the suspended Member shall automatically be reinstated to the status previously held.

Section 3. Action by Board

Within seven days after receipt of the recommendation of the MEC for modification, continuation, or termination of a summary suspension, the Board, acting through the Administrator, shall take action. Such action may be to affirm, to modify by increasing or reducing the discipline recommended, or to reject the recommendation. Such rejection shall have the effect of a remand to the MEC, which may then dismiss the matter or impose any corrective action for which Board approval is not required.

The Administrator shall, in writing, notify the MEC and, by certified mail, the affected Member, of the action. In cases to which the Fair Hearing Plan applies, the notice shall set forth the Member's rights and shall be accompanied with the documentation described in the Fair Hearing Plan (Article XI)

Section 4. Continuity of Patient Care

Immediately on the imposition of a summary suspension, the Chief of Staff, or responsible Medical Staff member, shall have responsibility to provide for alternative medical coverage for the hospitalized patients of the suspended Member. The wishes of the patient and the Member under suspension shall be considered whenever possible in the selection of such alternative coverage.

Article X. AUTOMATIC SUSPENSION/LIMITATION

Section 1. Imposition of Automatic Suspension

Automatic suspension or limitation shall be initiated whenever there is revocation, suspension, restriction or probation of a Member's state license or DEA certificate; whenever there is failure to satisfy a special appearance requirement; whenever a Member is excluded from participation in the Medicare, Medicaid or other Federal health care programs and is so listed on the Office of the Inspector General's List of Excluded Individuals/Entities; whenever a Member fails to maintain malpractice insurance required by the Bylaws and these Rules. Hearing and appellate review rights do not apply to the imposition of automatic suspension/limitation. Notice of the automatic suspension or limitation shall be promptly forwarded to the MEC, CC, appropriate Hospital departments, Administrator and, by certified mail, to the Member. In the case of automatic suspension, the Member's elected and appointed office shall be automatically terminated.

Section 2. State Professional License

- A. Revocation: When a Member's license to practice in the state of Alaska is revoked, there is simultaneous and automatic revocation of Professional Staff membership and all clinical privileges. Upon reinstatement of the Member's license to practice, he/she must reapply for Professional Staff membership and clinical privileges.
- B. Restriction: During the period in which a Member's license is limited or restricted in any way, those clinical privileges that have been granted within the scope of the limitation or restriction are similarly limited or restricted, automatically, as of the date such action becomes effective and throughout its term. Upon reinstatement of the Member's license to practice without such restrictions or limitations, he/she must reapply for those clinical privileges that were limited or restricted.
- C. Suspension: If a Member's license is suspended, the Member's Professional Staff membership and clinical privileges are automatically suspended as of the date such action becomes effective. Upon reinstatement of the Member's license to practice, he/she must reapply for Professional Staff membership and clinical privileges.
- D. Probation: If a Member is placed on probation by the relevant licensing authority, his/her Professional Staff membership and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term. Upon termination of the probation, he/she must reapply for membership and the clinical privileges that were subject to the probation.

Section 3. Drug Enforcement Administration (DEA) Certificate

If a Member's right to prescribe controlled substances is revoked, restricted, suspended or placed on probation by a proper licensing authority, privileges to prescribe such substances in the Hospital will also be revoked, restricted, suspended or placed on probation automatically. Upon reinstatement of the Member's DEA certificate, he/she must reapply for the privilege to prescribe controlled substances in the Hospital.

Section 4. Medicare, Medicaid and Other Government Programs

When a Member is excluded from Medicare, Medicaid or other government programs, there is a simultaneous and automatic revocation of Professional Staff membership and all clinical privileges. Upon reinstatement of the Members participating provider status, he/she must reapply for Professional Staff membership and clinical privileges.

Section 5. Professional Liability Insurance

A Member's Professional Staff membership and clinical privileges are immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Board. The Member may be reinstated within seven days of the date of the notice of suspension when proof of required coverage is provided to the Medical Staff Office with a reasonable written explanation of the Member's failure to maintain the minimum amount of professional liability insurance as required. If a Member fails to provide proof of insurance and reasonable explanation within the seven-day period, Professional Staff membership and privileges shall be suspended and he/she must reapply for Professional Staff membership and clinical privileges.

Section 6. Continuity of Patient Care

Immediately on the imposition of an automatic suspension, the President, or responsible Committee Chair, shall have responsibility to provide for alternative medical coverage for the hospitalized patients of the suspended Member. The wishes of the patient and the Member under suspension shall be considered whenever possible in the selection of such alternative coverage.

Article XI. FAIR HEARING PLAN

Section 1. Definitions

The following definitions apply to the provisions of this Fair Hearing Plan (the "Plan"):

- A. "Appellate review committee" means the group designated under this Plan to hear an appeal properly requested and pursued by an Affected Practitioner.

- B. "Hearing committee" means the committee appointed under this Plan to preside over an evidentiary hearing properly requested and pursued by an Affected Practitioner.
- C. "Party" or "parties" means the Affected Practitioner who requested the hearing or appellate review and the body or bodies who participate in the hearing or appellate review.
- D. "Affected Practitioner" means the applicant or Member against whom an adverse action has been recommended or taken.
- E. "Special notice" means written notification sent by certified or registered mail, return receipt requested.
- F. "Official notice" means the act by which the hearing committee will, without the production of evidence, recognize the existence and truth of certain facts relevant to the controversy and generally regarded as true.
- G. "Referral back" or "refer back" means the process whereby the Administrator or the appellate review committee requires a body to reconsider its previous recommendation. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made, and may include a directive for additional investigation or hearing.
- H. "Adverse action or recommendation" means any one of the unfavorable events listed in Section 2(A)(1) of this Plan, which has been recommended or approved for forwarding to the Board by the MEC, or which has been taken by the Board under circumstances in which no prior right to request a hearing existed. For purposes of this Plan, an adverse action or recommendation is not final until it has been adopted as final action by the Board after the Practitioner has had the opportunity of a hearing under this Plan.

Section 2. Initiation of Hearing

A. Triggering Events:

- 1. **Grounds for Hearing:** Except as otherwise provided in the Rules, the following recommendations or actions with respect to an individual Affected Practitioner shall, if deemed adverse under Subsection 2 below, be grounds for a hearing upon timely and proper request by the Affected Practitioner:
 - (a) denial of initial Professional Staff appointment;
 - (b) denial of Professional Staff reappointment;

- (c) suspension of Professional Staff appointment;
- (d) revocation of Professional Staff appointment;
- (e) denial of requested appointment to or advancement in Professional Staff category;
- (f) involuntary reduction in Professional Staff category;
- (g) suspension or limitation of the right to admit patients;
- (h) denial of requested Committee affiliation;
- (i) denial or restriction of requested clinical privileges;
- (j) involuntary reduction in clinical privileges;
- (k) suspension of clinical privileges;
- (l) revocation of clinical privileges; and
- (m) imposition of or increased scope of mandatory consultation requirement after the completion of the probation period.

2. **When Deemed Adverse:** A recommendation or action listed in Subsection 1 above is adverse only when it has been:

- (a) recommended by the MEC; or
- (b) taken by the Board under circumstances in which no prior right to request a hearing existed.

B. Notice of Adverse Recommendation or Action: The Administrator promptly gives the Affected Practitioner special notice of an adverse recommendation or action taken pursuant to Section 2(A). The notice shall:

- 1. Advise the Affected Practitioner of the recommendation or action, the reasons therefore, and his/her right to request a hearing pursuant to the provisions of the Rules and this Plan;
- 2. Summarize the rights of the Affected Practitioner in the hearing;

3. Specify that the Affected Practitioner has thirty days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Section 2(C) below;
 4. State that failure to request a hearing within the specified time period and in the proper manner will result in loss of rights to any hearing or appellate review on the matter that is the subject of the notice;
 5. State that any higher authority required or permitted under this Plan to act on the matter will not be bound by the adverse recommendation or action but may take any action, whether more or less severe, that it deems warranted by the circumstances;
 6. State that upon receipt of the Affected Practitioner's hearing request, the Administrator will notify the Affected Practitioner of the date, time and place of the hearing; and
 7. State that if the Affected Practitioner wishes representation by an attorney, he/she must so notify the Administrator *in writing* at least five days before the hearing.
- C. Request for Hearing: The Affected Practitioner shall have thirty days after receiving a notice under Section 2(B) to file a written request for a hearing. The request must be delivered to the Administrator either in person or by certified or registered mail.
- D. Waiver by Failure to Request a Hearing: An Affected Practitioner who fails to request a hearing within the time and in the manner specified in Section 2(C) will lose his/her right to any hearing or appellate review to which he/she might otherwise have been entitled. The Administrator shall promptly send the Affected Practitioner special notice of each action taken under any of the following sections and shall notify the President of the Medical Staff.
1. **After Adverse Recommendation by the MEC:** The Board, acting through the Administrator, shall consider the adverse recommendation within thirty days of receipt of the recommendation.
 - (a) If Administrator affirms MEC's recommendation. If the action of the Board, acting through the Administrator, affirms in all respects the MEC's recommendation it shall then become effective as the final decision of the Board.
 - (b) If Administrator modifies MEC's Recommendation. If, on the basis of the same information and material considered by the MEC in formulating its recommendation, the Administrator proposes a different action, then the

matter shall be referred back to the MEC for further consideration. After receiving a subsequent recommendation and any new evidence, the Administrator shall then take final action on the reconsidered recommendation. The Administrator shall send the Affected Practitioner notice of any such referral back, the subsequent recommendation of the MEC, and the action taken. The Affected Practitioner shall be entitled to request a hearing before the Board enters a final decision in the event that the Administrator proposes a more severe action than the action recommended by the MEC.

2. **After Adverse Decision by the Administrator:** If the Board, acting through the Administrator, proposes to take an action adverse to the Practitioner after a favorable recommendation by the MEC, the Administrator shall submit the matter to the MEC before taking final action. The procedure after referral back shall be as provided in Section 2(D)(1)(b).

Section 3. Hearing Prerequisites

- A. Notice and Time and Place for Hearing: When a proper request for a hearing is received, the Administrator shall deliver it to the Medical Staff Office and notify the MEC. The Medical Staff Office shall arrange and schedule a hearing, and the Administrator shall send the Affected Practitioner special notice of the time, place and date of the hearing. The hearing date shall not be less than thirty nor more than forty-five days after receipt of the request for a hearing, unless the Affected Practitioner requests an expedited hearing, in which case the hearing shall be arranged as soon as convenient for the parties, but in no event more than twenty-one days after the request for an expedited hearing.
- B. Statement of Issues, Events, and Witnesses: The notice of hearing must contain a concise statement of the Affected Practitioner's alleged acts or omissions, a list by number of the specific patient records in question, and any other reasons or subject matter forming the basis for the adverse action or recommendation. In addition, the notice shall include a proposed list of the witnesses (if any) expected to testify at the hearing in support of the adverse recommendation or decision. This statement, the potential witness list, and the list of supporting patient record numbers and other information it contains, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the Affected Practitioner requesting the hearing, and that the Affected Practitioner and the Affected Practitioner's counsel have sufficient time to study this additional information and rebut it.
- C. Witness List: The Affected Practitioner requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the Affected Practitioner's behalf within ten (10) days after receiving

notice of the hearing. Each witness list shall include a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time 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.

D. Appointment of Hearing Committee:

1. **By Administrator:** A hearing occasioned by an adverse recommendation by the MEC or an adverse action by the Board, acting through the Administrator, is conducted by a hearing committee, appointed by the Administrator after consulting with the chairperson of the Board and President, and composed of three health professionals. The Administration will request that the Alaska State Medical Board appoint one or more physicians to conduct the hearing. The affected Practitioner, the MEC, and the Board must agree on the appointee(s). None of the members of the hearing committee may be in direct economic competition with the Member/applicant or be involved in the case in any way. The President shall designate one of the appointees as Chair of the Committee.
2. **Service on Hearing Committee.** A Member is not disqualified from serving on a hearing committee merely because he/she has heard of the case or has knowledge of the facts involved or what he/she supposes the facts to be. The Member(s) whose adverse recommendation or action initiated the hearing shall not serve on the hearing committee. The members of the hearing committee must give fair and impartial consideration of the case.

Section 4. Hearing Procedure

- A. Personal Presence: The personal presence of the Affected Practitioner is required at the hearing. An Affected Practitioner who fails, without good cause, to appear and respond to questions at the hearing shall lose his/her right to a hearing.
- B. Hearing Officer: The hearing officer is appointed under Section 8(A), or if not appointed, the hearing committee chair shall be the hearing officer. This officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall determine the order of procedure during the hearing and shall make all rulings on matters of procedure and evidence.
- C. Representation: The Affected Practitioner may be accompanied and represented at the hearing by an attorney or other person of the Affected Practitioner's choice. The MEC and the Board, acting through the Administrator, if its recommendation or action prompted the hearing, shall appoint an individual to represent it.

Representation of either party by an attorney at law is governed by Section 8(B) of this Plan.

D. Rights of Parties: During a hearing, each party may:

1. Call and examine witnesses;
2. Introduce exhibits; and
3. Cross-examine any witness on any matter relevant to the issues.

If the Affected Practitioner does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.

- E. Procedure and Evidence: The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons might customarily rely in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. The committee is also entitled to consider all other relevant information that can be considered under the Rules in connection with credential matters. Each party shall be entitled, prior to, during, or at the close of the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. Oral evidence shall be taken only on oath or affirmation.
- F. Official Notice: In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state of Alaska. Parties present at the hearing must be informed of the matters to be noticed, and those matters must be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute any officially noticed matter by evidence or by written or oral presentation of authority, in a manner to be determined by the hearing committee.
- G. Scope of Review and Burden of Proof: The party whose adverse action or recommendation gave rise to the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. Thereafter, the burden shall shift to the Affected Practitioner who requested the hearing to come forward with evidence in response. After all the evidence has been submitted by both sides, the hearing committee shall decide if the adverse recommendation or action was justified.
- H. Hearing Record: A record of the hearing must be kept that is sufficient to permit an informed judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing

committee will use a court reporter to detail the proceedings. The hearing record shall also contain all exhibits or other documentation considered written statements submitted by the parties, and correspondence between the parties or between the hearing committee and the parties, if any, during the hearing process. The Affected Practitioner may request a copy of the hearing record at his/her own expense.

- I. Postponement: Requests for postponement of a hearing may be granted by the hearing committee only upon showing of good cause and only if the request is made as soon as is reasonably practical.
- J. Presence of Hearing Committee Practitioners and Vote: The entire hearing committee must be present throughout the hearing and deliberations.
- K. Recesses and Adjournment: The hearing committee may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing committee must reconvene in a timely manner and in any event the recess must not exceed ten days except by written consent of the Affected Practitioner. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be adjourned. Adjournment shall be no later than ten days after the hearing is closed.

Section 5. Hearing Committee Report and Further Action

- A. Hearing Committee Report: Within ten days after final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations, after review of the evidence, and shall forward the report along with the record and other documentation to the MEC. The Administrator shall promptly send a copy of the hearing committee report to the Affected Practitioner by special notice.
- B. Action on Hearing Committee Report: Within twenty-one days after receiving the hearing committee report, the MEC shall consider it and adopt, modify or change the recommendation or action. It shall transmit the recommendation together with the hearing record, and the hearing committee report to the Administrator.
- C. Notice and Effect of Result:
 - 1. **Notice**: The Administrator shall promptly send a copy of the recommendation to the Practitioner by special notice, to the Chief of Staff, to the MEC and to the Board.

2. **Effect of Favorable Recommendation by the MEC** If the MEC's result is favorable to the Affected Practitioner, the Administrator shall promptly forward it, together with all supporting documentation, to the Board, which, acting through the Administrator, may adopt or reject the recommendation, in whole or in part, or refer the matter back to the MEC for further consideration. After receiving a subsequent recommendation and any new evidence, the Board, acting through the Administrator, shall make a decision. If the Board's action is favorable, it becomes the final decision of the Board. If the Board's action is adverse, the matter shall be referred back to the MEC for reconsideration. If the Board's action after receiving the reconsidered recommendation of the MEC remains adverse, the special notice shall inform the Affected Practitioner of his/her right to request an appellate review by the Board as provided in Section 6 of this Plan. The Administrator shall promptly send the Affected Practitioner special notice informing him/her of each action taken under this Section, including a statement of the basis for the Board's decision.
3. **Effect of an Adverse Recommendation by the MEC:** If the Board, acting through the Administrator, adopts the adverse recommendation of the MEC, the special notice shall inform the Affected Practitioner of his/her right to request an appellate review by the Board as provided in Section 6 of this Plan. If, however, the Board, acting through the Administrator, renders a decision different from the recommendation of the MEC, the matter shall be referred back to the MEC for reconsideration. If the action of the Board, acting through the Administrator, after receiving the reconsidered recommendation of the MEC is favorable to the Affected Practitioner, it shall become the final decision in the matter. If the action of the Board, acting through the Administrator, is adverse to the Affected Practitioner, the special notice shall include a statement of the basis for the Board's decision and shall inform him/her of his/her right to request an appellate review by the Board as provided in Section 6 of this Plan.

Section 6. Initiation and Prerequisites for Appellate Review

- A. **Request for Appellate Review:** If, after a hearing the decision of the Board, acting through the Administrator, is adverse, an Affected Practitioner shall have ten days after receiving special notice under Section 5(C) to file a written request for an appellate review. The request must be delivered to the Administrator in person or by certified or registered mail and may include a request for a copy of the hearing committee report and record of all material not previously furnished to him/her that was considered. The cost associated with obtaining a copy of the hearing record shall be borne by the Affected Practitioner.

- B. Failure to Request Appellate Review An Affected Practitioner who fails to request an appellate review within the time and in the manner specified loses any right to an appellate review. At this point, the adverse action becomes final and, if applicable, a report will be made to National Practitioner Data Bank.
- C. Notice of Time and Place for Appellate Review: The Administrator shall deliver a timely and proper request to the Chairman of the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review that shall be not less than twenty-one days nor more than thirty-five days after the Administrator received the request; provided, however, that appellate review for an Affected Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may be reasonably made, but not later than twenty-one days after the Administrator received the request.

At least ten days prior to the appellate review, the Administrator shall send the Affected Practitioner special notice of the time, place and date of the review. The time may be extended by the appellate review committee for good cause and if the request is made as soon as is reasonably practical after discovery of the need for extension. If the Affected Practitioner wishes to be represented by an attorney at any appellate review, he/she must so notify the Administrator at least five days prior to the appellate review.

- D. Appellate Review Committee: Any party to an original hearing may request an appellate review of the recommendation of the hearing committee by an appellate review committee of the Board of at least three (3) members, one of which will be a family medicine physician from a Critical Access Hospital, or in the case of other specialties, a physician of like specialty. Requests for an appellate review must be made in writing and either delivered personally or sent by certified mail, return receipt requested, to the Administrator of the hospital within ten (10) days after such party's receipt of the written report of the hearing committee. The failure of any party to request an appellate review in a timely manner shall constitute a waiver of the right to appellate review.

Section 7. Appellate Review Procedure and Final Action

- A. Nature of Proceedings: The proceedings by the appellate review committee are a review based upon the hearing record, the hearing committee's report, all subsequent results and action, the written statements, if any, submitted pursuant to Section 7(B), and any other material that may be presented and accepted under Section 7(E). The purpose of appellate review is to review the record of earlier proceedings to determine if the recommendations and the action taken (1) involve substantial procedural compliance with this Plan, (2) are not arbitrary or capricious, and (3) are supported by substantial evidence. The appellate review committee may make a

recommendation different than the recommendation and action appealed from only if the appellate review committee finds that one or more of the requirements in subsections 7(A)(1), 7(A)(2), or 7(A)(3) are not supported by the record. “Substantial evidence” shall mean evidence that a reasonable person could accept as adequate to support a conclusion. It is not the task of the appellate review committee to substitute its judgment for the Board or determine which side presented the greater weight of evidence.

- B. Written Statements: The Affected Practitioner may submit a written statement containing objections to the findings, actions, and procedural rulings, together with his/her reasons. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review committee and the other parties through the Administrator at least ten days prior to the scheduled date of the review, except if the time limit is waived by the review committee. A similar statement may be submitted by the MEC whose adverse action occasioned the review, and if submitted, the Administrator shall provide a copy to the Affected Practitioner at least ten days prior to the scheduled date of the appellate review.
- C. Hearing Officer: The chair of the appellate review committee determines the order or procedure during the review, make all required rulings with the advice of the committee, and maintain decorum.
- D. Oral Statements: The appellate review committee, 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 appearing is required to answer questions put by any Member of the appellate review committee or any other party.
- E. Consideration of New or Additional Matters: New or additional evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the appellate review committee as the appellate review committee deems appropriate and only if the party requesting consideration of the new or additional evidence shows that it could not have anticipated the production of such evidence at earlier point in the proceedings. The requesting party shall submit to the Administrator a written description of the new or additional evidence as soon as it becomes aware of the evidence, but in no event later than three days prior to the scheduled date of the review. The Administrator shall immediately transmit the description to the appellate review body and the other party.
- F. Presence of Committee Members and Vote: All members of the appellate review committee must be present throughout the review and deliberations.

- G. Recesses and Adjournments: At the conclusion of the oral statements, if allowed, the appellate review shall be closed. The appellate review committee shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review committee shall be adjourned at the conclusion of those deliberations.
- H. Action by Appellate Review Committee: The appellate review committee may recommend that the Board affirm, modify or reverse the adverse recommendation or action, or in its discretion, may refer the matter back for further review and recommendation to be returned to it within twenty-one days. Within ten days after receipt of such recommendation after referral back, the appellate review committee shall recommend action. The appellate review committee shall promptly forward a report containing its recommendation, the hearing record, and all documentation to the Board. A copy of the report shall be sent to the Affected Practitioner by special notice.
- I. Action by Board: Within ten days after receipt thereof, the Board (not the Administrator) shall act taking into consideration the recommendation of the appellate review committee. It may either confirm, modify, or reject the recommendation of the MEC. If the decision of the Board is in accord with the last recommendation of the MEC, it shall be immediately effective. If the action of the Board has the effect of changing the MEC's last recommendation, the matter shall be referred to a joint conference committee as provided in Section 7(J) at the request of either the MEC or the Board. The action of the Board after receiving the joint conference committee recommendation shall be effective as the final decision on the matter. The Board shall inform the Affected Practitioner of its decision by special notice. If applicable, a report will be made to the National Practitioner Data Bank.
- J. Joint Conference Review: The joint conference committee shall consist of five members. The Board shall appoint three members, two from its own members, and one from administration. The Chief of Staff shall appoint two members from the Professional Staff. Within ten days after receiving a matter referred to it under this Plan, the joint conference committee shall convene to consider the matter and shall submit its recommendations to the Board.

Section 8. General Provisions

- A. Hearing Officer Appointment and Duties: The appointment and use of a hearing officer to assist at the evidentiary hearing with procedural matters is optional and is to be determined by the Administrator after consultation with the Chief of Staff. The chair of the hearing committee shall decide whether the hearing officer shall only provide advice or whether they shall preside at the hearing. A hearing officer may or may not be an attorney at law but must be experienced in conducting hearings. A

hearing officer may not vote and may not be in direct economic competition with the Affected Practitioner.

B. Attorneys:

1. **At Hearing:** The Affected Practitioner may be represented by an attorney at the hearing, provided he/she notified the Administrator at least five days prior to the hearing.
2. **At Appellate Review:** The Affected Practitioner may be represented by an attorney at an appellate review provided he/she so notified the Administrator at least five days prior to the appellate review.
3. **Responsibility for Attorneys:** If an Affected Practitioner elects to be represented by an attorney, he/she will be solely responsible for payment of all his/her attorney fees no matter which party prevails at the hearing.
4. **Equal Representation and Preparation Assistance:** Only if the Affected Practitioner has requested representation by an attorney at the hearing or appellate review may the MEC or the Board be allowed such representation. The MEC or the Board shall then give the Affected Practitioner or his/her attorney notice of who will represent the MEC or the Board. The foregoing provisions shall not be deemed to deprive the Affected Practitioner, the MEC, or the Board of the right to legal counsel in connection with preparation for a hearing or an appellate review.

- C. **Number of Hearings and Review:** Notwithstanding any other provision of the Rules or of this Plan, no Practitioner is entitled to request more than one evidentiary hearing and one appellate review with respect to the adverse recommendation or action triggering the right.

Article XII. PROFESSIONAL STAFF ASSISTANCE PROGRAM

Section 1. Early Assistance Program

All employees and Professional Staff Members are strongly encouraged to express concerns about a Member's health and to make a referral to the Chief of Staff, Administrator, or the Medical Staff Office. Confidentiality and peer review protection of the Professional Staff Member referred for assistance or self-referred will be maintained according to the PHS and Professional Staff confidentiality policies and by applicable laws of the State of Alaska.

Section 2. Assistance for Impaired Members

The term "impaired professional" is used to describe the practitioner who is prevented by reasons of illness or other health problems from performing professional duties at the expected level of skill and competency. Impairment also implies a decreased ability and/or willingness on the part of the affected individual to acknowledge the problem or to seek help to recover. This places the professional at risk and may pose an actual or potential risk to public health and safety. Most conditions of impairment are treatable illnesses. Appropriate treatment can be arranged for assessment, treatment support and monitoring for recovery and appropriate return to work.

Article XIII. CLINICAL COMMITTEES OF THE PROFESSIONAL STAFF

Clinical Committee ("Committee") meetings shall be held as often as necessary to accomplish the patient care and education goals of the Committee and as required by regulation. A record of the proceedings shall be maintained and reports forwarded to the MEC. The Committee Chair shall be appointed by the Chief of Staff with the input of the Active Members of the Medical Staff falling within the that Committee's purview and the concurrence of the MEC and the Administrator. Committee specific responsibilities may be identified by individual committees with approval of the MEC. The Medical Staff may act as a committee of the whole or may act through corresponding interdepartmental committees of the hospital at the staffs discretion in carrying out these responsibilities. When using an interdepartmental committee, the physician assigned to the committee shall act for the medical staff at the interdepartmental committee meetings and ensure that the decisions of those meetings are conveyed to the entire medical staff. Upon review by the entire Medical Staff, a committee chairman maybe tasked with revisiting decisions made by an interdepartmental committee to ensure that the final decisions are acceptable to the medical staff.

Section 1. Clinical Committees

The Quality Assessment of Care at Providence Valdez Medical Hospital shall be accomplished through the following Medical Staff Committees.

A. QUALITY MANAGEMENT COMMITTEE

The duties of this committee shall be as follows:

- (1) Oversight of and participation in the hospital performance improvement activities, review of statistics, interventions and outcomes.
- (2) Report on the outcomes of transfusion and surgical indications monitoring.
- (4) Review and approval of the hospital utilization, quality and risk management plans.

- (5) Oversight of the hospital Safety Committee.
- (6) Review and approval of all hospital policies and procedures, and forms which impact the medical staff.
- (6) Review outcomes of Medical Record Documentation Review and make recommendations for performance improvement.

B. PHARMACY AND THERAPEUTICS COMMITTEE

- (1) To evaluate the use of medications;
- (2) To develop drug utilization policies and evaluate practices within the hospital, and prevent unnecessary duplication in stocking drugs and combinations of drugs.
- (3) To develop and periodically review the drug formulary.
- (4) To establish standards concerning the use and control of investigational drugs and research in the use of recognized drugs. To evaluate clinical data concerning new drugs or preparations requested for use in the hospital.
- (5) Review of statistics and particulars of medication related errors, interventions and performance improvement activities for the prevention and reduction of medication errors.

C. INFECTION CONTROL COMMITTEE

The duties of this committee shall be:

- (1) To educate and orient the physicians and hospital staff in the prevention and control of infection, and to take or recommend action when indicated to prevent infections
- (2) To determine scope of infection control surveillance activities.
- (3) To review as appropriate, immunizations and potential infections relating to employee health; to take or recommend appropriate action to prevent, reduce or eliminate problems identified.
- (4) To review infection control surveillance statistics, evaluate the occurrence of infections within the hospital and take appropriate action.

D. EMERGENCY , CRITICAL CARE, O.B., TRAUMA, SURGICAL & ANESTHESIA COMMITTEE

The duties of this committee shall be:

- (1) Establish rules of conduct, treatment and care in the E.R. and for Critical Care Patients.
- (2) Provide input into development and maintenance of a disaster preparedness plan.
- (3) monitor the care of patients in the E.R. take or recommend appropriate action to reduce or eliminate identified problems.
- (4) To evaluate the need for new or additional equipment in the hospital
- (5) To develop policies for O.B., and perform annual review and update of all related policies. Development and review of Surgical/Anesthesia Policies and Procedures. Develop and review Trauma Policies and procedures.
- (6) To conduct review of care provided in the hospital and take or recommend action when necessary to improve the quality of patient care.
- (7) To assist with prioritization of the new equipment listed for purchase for the department.

Section 2. Qualifications and Responsibilities of Committee Chairs

Each Committee Chair shall be a Member of the Active category, shall have clinical privileges at Hospital and shall be willing and able to faithfully discharge the functions of the office. .

The Committee Chair is accountable for quality management activities, and may designate a sub-committee, or an individual to conduct review activities.

Removal of a Committee Chair from office may be initiated upon the recommendation of the MEC, or by petition of ten percent of the Active and Active Provisional Committee Members or by recommendation of the Administrator. Removal requires a majority vote of the Active and Active Provisional Members of the Committee and must be approved by the MEC.

Renewal or replacement of physician chair will be the first Medical Staff meeting in January and shall be responsible for the following duties:

1. Continuous assessment and improvement of the quality of care and services provided by Professional Staff Members within that Committee's purview;
2. Maintenance of quality of the professional performance of all Committee Members who have delineated clinical privileges;
3. All clinically related activities of the Committee;
4. All administratively related activities of the Committee, unless otherwise provided for by the Hospital;
5. Assess and recommend off-site sources including clinical services provided by telemedicine for needed patient care services not provided by ;
6. Integrate the Committee activities into the primary functions of Hospital;
7. Coordinate and collaborate with other committees on Hospital-wide services;
8. Review policies and procedures that guide and support the provision of services which are developed by the Hospital departments;
9. Provide input into determination of qualifications and competence of committee or service personnel who are not Members who provide patient care services;
10. Maintain quality management programs, as appropriate;
11. Orientation and continuing education opportunities for Committee Members; and

Article XIV. ADMINISTRATIVE COMMITTEES

Section 1. Medical Executive Committee

The Medical Executive Committee shall consist of Chief of Staff, Assistant Chief of Staff, , Secretary/Treasurer. and member-at-large who shall each serve a two-year term. All terms of office commence at the annual meeting.

The Assistant Chief of Staff, Secretary/Treasurer shall be selected by the Medical Staff members as described in Article XVI (Elections).

Duties of the secretary/treasurer are to supervise the collection and accounting of any funds that may be collected in the form of staff dues, assessments, or application fees.

Section 2. Credentials Committee

This function is served by the committee of the whole.

Section 3. Bylaws Committee

This function is served by the committee of the whole

Section 4. Other Administrative Committees

This function is served by the committee of the whole

Article XV. PROFESSIONAL COMMITTEE MEETINGS

Section 1. Notice

A written notice and agenda items shall be provided to the Members at least four days prior to the meeting date.

Section 2. Quorum

There shall be no minimum number of Active Members of a Committee to constitute a quorum at a properly called meeting.

Section 3. Manner of Action

Business at Committee meetings will be conducted informally. However, in the event of conflict the latest edition of *Robert's Rules of Order* shall control.

Except as otherwise provided, the action of a majority of the Members present and eligible to vote at a meeting shall be the action of the Committee.

Section 4. Committee Meetings

A meeting of a Committee may be called at the request of the Chair of the Committee. A meeting must be called by the Chair at the written request of the Board, MEC or the Chief of Staff. A meeting must be called if at least fifty percent of the current Active Members of the Committee request a meeting.

Section 6. General Professional Staff Meetings

This committee shall consist of Chief of Staff, Administrator, Assistant Administrator, Assistant Chief of Staff, Secretary/Treasurer and active medical staff.

Article XVII. ELECTIONS

Section 1. Nominating Committees

This function is served by the committee of the whole

Section 2. Elections

A candidate shall be elected upon receiving a majority of the valid votes cast.

Article XVIII. ADDITIONAL POLICIES

Section 1. Admission, Placement, Length of Stay and Discharge of Patients

- A. **Admissions:** A patient may be admitted to the Hospital only by a Member with admitting privileges.

Members shall be responsible for the medical care and treatment of their patients in the Hospital and for the prompt completion of an accurate medical record. Whenever these responsibilities are transferred, temporarily or permanently to another Member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

Admissions will fall into three basic categories - emergency, urgent and elective. All categories of admission shall be reviewed as necessary by the respective Hospital Administrator and President or their designees, to determine priority when an admission for a specific day is not possible.

The initial assessment and treatment must be accomplished within a time frame commensurate with the patient's severity of illness, not to exceed twelve hours.

The admitting Member or Member designee will be responsible to evaluate each patient at least every 24 hours and document findings in the progress notes.

1. **Emergency Admissions:** Members admitting emergency cases shall be prepared to justify to the MEC and Administrator that said emergency admission was a bona fide emergency, as defined in Article VII, Section 3 of these Rules. The history and physical examination must clearly justify the emergency of the patient being admitted, and these findings must be recorded on the patient's chart as soon as possible after admission. A patient admitted emergently, who does not have an established relationship with a Member, will be assigned an appropriate Member according to the emergency call schedule.
2. **Urgent Admissions:** An urgent admission is a case in which undue or prolonged delay in securing admission might be injurious to the patient's health or well-being.
3. **Elective Admissions:** An elective admission is a non-urgent case where a patient's health will not be endangered by a delay in hospitalization.

- B. **Placement of Admissions:**

1. The patient shall be assigned a bed in the general area of the hospital appropriate to the patient's diagnosis.

2. Transfers to other settings occurs based on assessed individual care needs and with an order from treating physician.
- C. Length of Stay: The attending Member is required to document the need for continuing hospitalization.

Upon request of the Utilization Review designee, the attending Member will provide written justification of the necessity for continued hospitalization, a progress note will be dictated or written in the patient chart.

- D. Discharge: Patients shall be discharged only on a written order of the attending Member or authorized Practitioner. Should a patient leave the Hospital against the advice of the attending Member, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

In the event of a death in the Hospital, the deceased shall be pronounced dead by a physician within a reasonable time. Death pronouncements may be made by nurses in accordance with the respective Hospital policy on death pronouncement. The body will not be released until an entry has been made and signed in the medical record of the deceased. The Medical Examiner is notified and the Medical Examiner releases the body. All mortalities require a complete discharge summary.

An autopsy will be referred to the Medical Examiner.

- E. Transfer of Patients: Once a patient is admitted to a Hospital (including the Emergency Room), the patient shall not be transferred to another medical care facility unless the following conditions are met:
- a. The attending Member has written a transfer order;
 - b. Arrangements have been made for the patient's admission with the other facility, including concurrence of the receiving physician and the hospital's consent to receive the patient; and
 - c. The patient is considered sufficiently stabilized for transport.

All pertinent medical information necessary to insure continuity of care must accompany the patient, including documentation of whether or not the patient requests cardiopulmonary resuscitation and whether an advance directive exists.

A transfer demanded by an emergency or critically ill patient, or his/her legal representative if the patient is incapacitated, is not permitted until a Member has explained to the patient, or his/her legal representative, the seriousness of the condition, and generally not until a Member has determined that the patient's condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient, or his/her legal representative, refuses to sign the

release, a completed form without the signature and a note indicating refusal to sign must be included in the patient's medical record. The above is also applicable when a transfer is necessitated due to the services not being available at the Hospital. All such transfers shall be in compliance with Federal and State laws, including EMTALA.

- F. Medical Screening Examinations: Medical screening examinations within the capability of the Hospital will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations are defined as:

1. Members with clinical privileges; and
2. The trained RN for adults for Pediatrics, will triage and initiate standing protocols as appropriate for every patient who presents to the Emergency Department. He/She will contact the Physician on Call for these presenting patients as outlined in Policy 920.007 (Initial Screening Examination in the Emergency Department). This is in accordance with State Operations Manual App. V Interpretive Guidelines, Responsibilities of Medicare Participating Hospitals in Emergency Cases. (489.24a Interpretative Guidelines-patient presenting to ED requesting EMS, Triage, Prioritizing, Diagnosing 489.24b-Stabilizing, Transfer or Discharge). Physician will provide diagnosis and oversees plan of care.

Section 2. Medical Records

The content of the medical record must be sufficiently detailed and organized to enable:

1. The Member responsible for the patient to provide continuing care, determine the patient's condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient's response to treatment;
2. A consultant to render an opinion after a patient examination and review of the medical record;
3. Another Member to assume patient care at any time; and
3. The retrieval of pertinent information required for utilization review, quality assessment activities, and transfer recommendations.

A. General: In collaboration with Hospital personnel, the attending Member is responsible for the preparation of a complete and legible medical record for each patient. The contents shall be current, pertinent, and include the following, as applicable:

1. Patient name, address, date of birth, and legal representative, if appropriate;
2. For patients receiving mental health services, the patient's legal status;
3. Applicable details of any emergency patient care provided prior to arrival, including transfer agreements;
4. Evidence of patient's Advance Directives;
5. Evidence of patient's signed Informed Consent for all invasive procedures except venipuncture and intravenous therapy;
6. Member's initial assessment (History & Physical) including patient's chief complaint, history of present illness, medical history, physical examination, pertinent review of systems, pertinent personal and family history, diagnostic impressions. Where appropriate, assessment of emotional, behavioral, social, educational, nutritional and/or functional status is also noted;
7. Member's treatment plan;
8. Dated, timed and signed orders for all diagnostic and therapeutic tests performed, and all subsequent findings and results. The responsible Member, designee or authorized Practitioner are required to sign all verbal/telephone orders within 72 hours of the verbal/telephone order(s) being received; Narcotic verbal/telephone orders are required to be signed within 24 hours of the order(s) being given.
9. Member's report of all operative and invasive procedures performed;
10. Dated, timed and signed Progress Notes signed by a Member or authorized practitioner. All patient reassessments, revisions to the treatment plan, clinical observations, and patient responses to treatment are in the Progress Notes.
11. Every medication ordered or prescribed for an inpatient, and every medication dispensed to, or prescribed for, an ambulatory patient or an inpatient at discharge;
12. Transfer summary and referrals, as applicable;
13. Member's Discharge Summary as delineated in Section 2 (G); and
14. Autopsy report, if applicable.

B. History and Physical (H&P): A complete patient admission history and physical examination, or prenatal record, shall be written or dictated within 24 hours of admission and prior to any operative or invasive procedure requiring routine monitoring during the procedure by a Member with those privileges or authorized practitioner. This report must include all pertinent findings from an assessment of all body systems and related information as delineated in Section 2(A.6).

If a complete history and physical examination or prenatal record, has been performed within thirty (30) days of a patient's Hospital admission by a Member, a

durable, legible copy of the H&P may be used for the medical record. An Addendum with documentation of any changes must be noted and if no changes, then documentation stating such must be written and dated within 24 hours of admission and/or prior to any operative or invasive procedure.

A Member may include in the medical record an H&P report or prenatal record submitted by a non-Member Practitioner if it is clinically complete and relevant to current patient care and has been performed within thirty (30) days of admission. However, the Member must cosign the H&P report submitted by the non-Member Practitioner, and make an interval note or addendum on the day of admission that includes any documented changes in the patient's history and physical status.

When an H&P is not recorded in the medical record prior to any operative or invasive procedure requiring routine monitoring during the procedure, the procedure shall be cancelled. If a Member documents in the patient's medical record that serious harm would result to the patient or the patient's life would be endangered if the procedure did not proceed as scheduled without the presence of the H&P, this policy may be suspended. However, the Member must sign, date and time a statement of the special circumstances in the patient's medical record prior to the procedure. The H&P must be recorded immediately following the procedure.

- C. Preoperative Diagnosis and Operative Procedure Reports: The patient's preoperative diagnosis must be recorded in the medical record prior to any operative or invasive procedure by the attending Member. Operative reports shall be dictated or written immediately by a Member following a surgical or invasive procedure and must include the name of the Member and all assistants and describe the:
1. Findings;
 2. Technical procedures used;
 3. Specimens removed;
 4. Postoperative diagnosis; and
 5. Complications.

An operative progress note is entered in the medical record immediately after the procedure to provide pertinent information for Members and Practitioners providing patient care.

- D. Anesthesia Record: The medical record of patients receiving anesthesia, with the exception of local only, shall include:
1. A record of the pre-anesthesia patient visit;
 2. The anesthesia record; and
 3. A record of the post-anesthesia patient visit or evidence that the patient meets discharge criteria as set by the Anesthesia Sub-Committee.

All parts of the anesthesia record must be signed by the appropriate Member.

- E. Teaching Cases: The attending Member, when acting as a preceptor, shall authenticate all history and physical examinations, operative reports, and discharge summaries recorded by Practitioners enrolled in an authorized training, residency or fellowship program.
- F. Consultations: Consultations shall document a review of the patient's medical record by the consultant, pertinent findings from the patient examination, and the consultant's opinion and recommendations in the patient's medical record. When operative or invasive procedures are anticipated, the consultation note shall, except in documented emergency situations, be recorded prior to the procedure. A consultation report may be used in lieu of an H&P if it contains the pertinent required data and is performed within 24 hours of admission and prior to an operative or invasive procedure, or a potentially hazardous diagnostic procedure.
- G. Reports: All reports of, but not limited to: pathology and clinical laboratory examinations, radiology reports, or treatment reports, anesthesia records, and reports of any other diagnostic or therapeutic procedures, should be completed promptly, authenticated, and maintained in the paper/electronic medical record, upon completion. All critical test results, as determined by the department, shall be reported to the attending practitioner, with a verbal confirmation of the results by the attending practitioner.
- H. Discharge Summary: All medical records shall be as complete as possible at discharge and the discharge summary shall include:
1. A concise summary of the reasons for hospitalization;
 2. Significant findings;
 3. Hospital course;
 4. All procedures performed and treatment rendered;
 5. Final diagnoses including all diagnoses treated at this encounter;
 6. Patient's condition at discharge;
 7. Instructions regarding diet, medication, activity level and follow-up care; and
 8. Post-hospital instruction (as described below).

A discharge progress note may be substituted for the summary with specific required information included for those patients with conditions and interventions of a minor nature who require less than a 48 hour hospitalization, including uncomplicated normal newborn infants and uncomplicated obstetric deliveries. All mortalities require a complete discharge summary.

- I. Post-Hospital Instruction: At discharge, the patient or representative will be provided with discharge instructions. The instruction should be appropriate for the medical condition, operative, invasive or diagnostic procedure for which the patient was hospitalized and should be communicated in lay terms.

- J. Ambulatory Surgery (Day Surgery) Records: A short form medical record, in addition to the operative/procedure report, is acceptable in ambulatory surgery. The short form shall include patient identification data, a medical history, physical findings, dated, timed and signed therapeutic and diagnostic orders, documentation of all treatment, post-operative assessment, information sufficient to substantiate the diagnosis and treatment, reports of procedures, tests and results, dated and signed diagnostic impressions, patient disposition and post-hospital instructions. The history and physical and operation report/procedure report shall be authenticated by the attending member.
- K. Emergency Medical Record: When emergency care is provided, an emergency medical record shall include the time and method of arrival, patient's physical examination and findings, treatment rendered, conclusions at the termination of treatment including final disposition, patient's condition at discharge, and post-hospital instructions (including a work release, if applicable) or follow-up care. If a patient is transferred to another facility, the transfer process shall be fully documented in the medical record. If a patient leaves the Hospital against medical advice (AMA), this shall also be noted. A copy of the record of emergency services provided shall be communicated to the Member, practitioner or agency responsible for any follow-up care.
- L. Authentication: All entries in the medical record shall be dated, timed and authenticated either by written signature or electronically (computer authentication).
- M. Abbreviations: A list of medical record "do not use abbreviations" and "approved abbreviations" will be maintained at Hospital.
- N. Preprinted Order Sets: Standing order sets are preprinted orders that apply to a specific patient population and are approved and reviewed according to the Standing Order Policy.
- O. Availability of Records: The medical records of patients being treated in the Hospital shall be available to appropriate Members and authorized Practitioners at the nursing station during the hospitalization. After patient discharge, the medical record must be sent to the Hospital's Health Information Management Department (HIM).

All patient medical records are the property of the Hospital and may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

- O. Access to Records: Access to patient medical records shall be afforded to Members for bona fide studies and research consistent with the preservation of confidentiality of personal information concerning the individual patients and Members. Members

desiring to conduct research involving the review of patient medical records must submit a letter to the Chief of Staff and Administration explaining the purpose and conduct of the research. The Health Information Manager, or designee, will arrange a schedule for the medical record review upon receipt of written approval from the Chief of Staff.

Researchers are required to sign a statement that they will handle the information confidentially and use it only for the approved purpose and that they will protect patient confidentiality.

- Q. Life-Sustaining Treatment: Written Member orders must appear on the medical record in all instances where cardiopulmonary resuscitation or other life-sustaining treatment should not be performed. These orders shall follow current Hospital policies and the patient's Advance Directives. Member documentation of discussions with patient/family must be signed, timed, dated and included in the medical record.
- R. Incomplete Medical Record Patient medical records will be complete within thirty (30) days of patient discharge.

A complete medical record at the time of patient discharge encompasses all the applicable items specified in this Section 2(A). If a complete medical record cannot be achieved due to the unavailability of final laboratory or other essential reports at the time of patient discharge, the medical record will be available as paper record or electronically.

When a Member has a scheduled absence from the area, this period of time will not be used for calculating medical record delinquency if Member's medical records are current the week preceding the absence. The Member is obligated to notify the Hospital HIM Department in advance of such absences.

1. Incomplete Medical Record

If any Member's portion of the medical record is incomplete after patient discharge, the Hospital HIM Department will send an e-mail notice to the Member at 20 days aging until chart is completed.

If the Member's portion remains incomplete four weeks after patient discharge, the deficiency plan will be followed according to current Professional agreement

2. Member Deficiency plan for Incomplete Medical Records: payment for professional services may be withheld by Hospital. .

- S. Incomplete Operative, Invasive Procedure Report: Operative and invasive procedure reports will be completed immediately after the operative or invasive procedure.

Whenever a Member fails to complete an operative or invasive procedure report within 24-hours following the procedure, the Hospital HIM Department will document the delinquency and provide a quarterly summary, by Member, to the Quality Management/Medical Staff Department.

Section 3. General Conduct of Care

A. Orders:

Member or authorized Practitioner orders must be written clearly, legibly and completely, including date, time and signature. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "renew," "repeat" and "continue" orders are acceptable if they refer to a specific order. All previous orders are canceled when patients go to surgery. All orders must be rewritten when a patient is transferred to another level of care.

Verbal/Telephone Orders:

All orders for treatment shall be written legibly dated and timed. An order shall be considered to be in writing when dictated to a qualified individual and signed by the responsible practitioner. Preprinted physician orders are permitted, and are treated in the same manner as verbal orders. Individuals qualified to accept verbal orders in their area of practice are 1) licensed nurses; 2) registered pharmacists; 3) dietitians registered with the American Dietetic Association; 4) therapists registered with the American Association of Respiratory Therapists and certified respiratory therapy technicians, and 5) registered or licensed physical therapists. Verbal/telephone orders shall be signed by the person to whom they were dictated per the practitioner who gave them. At the practitioner's next visit the attending practitioner shall sign verbal/telephone orders. All verbal orders must be signed, dated and timed within 72 hours. Verbal orders for medications may be accepted only by a licensed nurse or pharmacist. Verbal/telephone orders involving Schedule II drugs must be signed, dated and timed within 24 hours.

All drugs and medications administered to the patient shall be those listed in the latest edition of United States Pharmacopoeia, American Hospital Formulary Service, or A.M.A. Drug Evaluations. Drugs for IRB approved clinical investigations may be exceptions to this rule. These investigational drugs shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, meet all regulations of the Federal Drug Administration and be approved by IRB's of approved institutions.

Members should use drugs that are on the Hospital Formulary as approved by the Hospital Pharmacy and Therapeutics Committee. When a non-formulary drug is ordered, and in the professional opinion of the Practitioner a suitable, therapeutically equivalent, formulary alternative is not available, the pharmacy will make every effort to obtain the non-formulary agent as soon as possible or the physician can specify that the patient's own medication may be used. As permitted by State law and authorized by the P&T Committee, the Pharmacy will automatically substitute generically equivalent drugs provided that:

1. the drugs are manufactured by an approved vendor;
2. the drugs are therapeutically equivalent and conform to USP standards;
3. the generically substituted drugs are of lower cost; and
4. the Practitioner does not indicate on the order that the prescribed brand must be dispensed.

Therapeutic interchange of therapeutically equivalent, but not generically equivalent drugs is permitted on a case by case basis when authorized by the Regional P&T Committee and approved by the appropriate MEC. Medications shall be administered only on the written or verbal order of the Member or authorized Practitioner. Medications authorized by the Member or authorized Practitioner and documented in the patient's chart for self-administration may be kept by the patient and may be self-administered.

B. Consultations: Consultation with a qualified Member is the responsibility of the attending Member and is recommended in cases when:

1. The patient is not a good risk for surgery or treatment;
2. The diagnosis is equivocal;
3. There is doubt as to the appropriate therapeutic measures or procedure to be utilized;
4. Consultation is required by law;
5. The patient is known or suspected to be suicidal;
6. The patient or family requests consultation.
7. Professional Staff or Hospital policies require it;

The consultant shall make and sign a record of the findings and recommendations in every case. A satisfactory consultation shall include examination of the patient and

the medical record. The patient's attending Member is responsible for requesting consultations when indicated.

C. Radiologic Services: All requests for x-rays should be considered a consultation. Appropriate clinical information must be provided with each radiologic request.

D. Laboratory Studies:

1. Admission Requirements: Admission studies are performed at the request of the attending Member. No specific laboratory studies are required.
2. Outside Laboratory Studies: Photocopies of tests performed by an outside state-licensed laboratory may be incorporated in the patient's record.

Reports of pathology and clinical laboratory examinations, radiology reports, or treatment reports, anesthesia records, and reports of any other diagnostic or therapeutic procedures, must be completed promptly, and the original shall be authenticated and filed in the medical record, upon completion.

E. Requests for Autopsies: To insure that autopsies are performed when indicated and the results are used as a source of clinical information in quality assessment and improvement activities, the following criteria should be used to identify deaths in which an autopsy should be considered. The Medical Examiner's case load may limit the practicality of obtaining autopsies:

1. Deaths in which an autopsy may help to explain unknown and unanticipated medical complications to the attending Member;
2. All deaths in which the cause of death is not known with certainty on clinical grounds;
3. Deaths in which an autopsy may help to allay concerns of the family and/or the public regarding the death;
4. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies;
5. Deaths of patients who have participated in clinical trials (protocols) approved by the Institutional Review Board;
6. Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction;

7. Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, and for which the attending Member determines that autopsy may disclose unexpected findings or illnesses. Examples include the following: (a) persons dead on arrival at the Hospital, (b) deaths occurring in the Hospital within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized;
8. Deaths resulting from high-risk infectious and contagious diseases;
9. All obstetrical deaths;
10. All neonatal and pediatric deaths;
11. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplant organs; and
12. Deaths known or suspected to have resulted from environmental or occupational hazards.

The patient's attending Member will determine if any of the above criteria pertain to the immediate situation and if so, request an autopsy from the family. The Member or other appropriate Hospital staff will obtain a family member's signature on the authorization form and document in the patient's chart that an autopsy is being obtained. All autopsies will be referred to the Medical Examiner when the autopsy is being performed.

Section 4. General Rules

- A. General Consent: Each patient's medical record must contain evidence of the patient's or his/her legal representative's general consent to Hospital services.

Informed Consent: The attending Member is responsible for obtaining the patient's or his/her legal representative's informed consent for the following procedures and treatments: anesthesia, surgical and other invasive and special procedures, use of experimental drugs or devices, HIV testing, radiation or chemotherapy, blood transfusion, initial dialysis, genetic testing and other procedures, as appropriate.

Evidence of the informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information (refer to Hospital policy):

1. Patient identity;

2. Date when patient/legal representative signed the form;
3. Nature of the procedure or treatment proposed to be rendered;
4. Indication that the Member has explained to the patient in general terms and common language the procedure or treatment to be undertaken, that there may be alternative procedures or methods of treatment, if any, that there are risks, if any, to the procedure or treatment, and the probable length of time for recuperation;
5. If the patient/legal representative wants a more detailed explanation, include an indication that the Member disclosed in substantial detail the procedure, the viable alternatives, and the material risks, unless to do so would be materially detrimental to the patient; and
6. The name of the Member who discussed the procedure/treatment with the patient/legal representative.

An informed consent must be signed by the patient or on the patient's behalf by the patient's legal representative. When signed by a legal representative, the consent must be witnessed with date/time/signature by a third party.

An informed consent obtained per telephone: A consent for any procedure may be received by telephone if a written consent cannot be obtained before the procedure. The telephone consent is to be witnessed by two persons, and an immediate written or faxed consent is to be requested during the telephone conversation.

If circumstances arise where the patient's life or health are at risk and time does not permit the Member to obtain informed consent prior to a procedure or treatment specified above, such circumstances must be explained in the patient's medical record. Where possible, two Members shall document the immediate risk to the patient's life or health that necessitates proceeding without informed consent.

Special requirements for informed consent in cases of experimental drugs and devices shall be specified by the corresponding IRB.

- B. Disposition of Tissue Removed at Surgery: All tissues and foreign bodies removed during surgery shall be sent to the designated pathologist who shall make such examination as may be considered necessary to arrive at a pathologic diagnosis and report.

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

1. The following surgical specimens may be submitted for examination, but are exempted from the above requirement:
 - a. foreign bodies (i.e., bullets) that for legal reasons are given directly to law enforcement personnel;
 - b. specimens known to rarely, if ever, show significant pathologic changes and removal of which is recorded in the medical record, such as foreskins from newborns, and toenails and foreign bodies easily identified and described.
 - c. placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics;
 - d. teeth, provided the number, including fragments, is recorded in the medical record; and
 - e. in addition to the above, surgically excised tissues may be submitted to investigative laboratories for analysis or processing after receiving informed consent from the patient, if applicable, and after providing sufficient tissue for examination by the pathologist to arrive at a pathological diagnosis.

Section 5. Emergency Call

The MEC will designate appropriate Members for the published Emergency Call List. All Active and Active Provisional Physician Members of the Professional Staff who hold core privileges in their specialty areas are required to take emergency hospital call. Such call shall include emergency situations within the Emergency Department, acute care, extended care, and other service areas of the hospital.

The MEC will be responsible for granting any exclusions to the mandatory call requirements.

The Member on call must be available to respond within thirty (30) minutes to meet the needs of the patient and may not delegate his or her responsibility to a Physician who is not a Member.

Patients, who do not have a relationship with a Member and who require admission, will be assigned to the appropriate Member according to the published Emergency Call List. For follow-up to an Emergency Department visit, the Members on the Emergency Call List shall see the referred patient once within a reasonable time frame as defined by the patient's medical condition, regardless of the patient's ability to pay. Further aftercare may be referred elsewhere at the discretion of the Member.

Section 6. Confidentiality of Credentialing/Privileging Information

A Member's credentials and quality files, all committee minutes in which credentialing, privileging or quality issues are discussed will be maintained in a secure environment to ensure confidentiality and protection from discoverability and may only be disclosed to:

- A. The CC and MEC;
- B. The Committee Chair or designee;
- C. The Chief of Staff or designee;
- D. The Administrator or designee on a need-to-know basis and with knowledge of the President;
- E. Medical Staff Services personnel;
- F. Any body entitled by law.

The Member may review his/her file in the presence of the Medical Staff office personnel or the designee, as long as the confidentiality of the source is maintained, if necessary. Member credentials files are the property of the Professional Staff and the Hospital, and may not be removed from the Hospital premises for any purpose. Any request received for the above information from outside agencies, by subpoena, by any person or agency other than those noted above, shall be referred by the Medical Staff Coordinator to the Chief of Staff or the Administrator and the affected member will be notified.

Section 7. Internet Access and Electronic Mail Accounts

- A. Members and their office staff may obtain limited Internet access through the Hospital firewall, and electronic mail accounts on the Hospital servers.
- B. Members and their office staff shall be subject to the Hospital policies and procedures on appropriate Internet and e-mail use (a copy of such policies and procedures shall be included in the information packets applicants receive when applying for Professional Staff membership).
- C. Use of the Internet through Hospital firewall is for business purposes only, with occasional personal use permitted with discretion. Hospital employs techniques to limit access to inappropriate Internet sites. Use of the Internet by individuals is monitored by the Hospital. Some applications and sites on the Internet may not be properly displayed through the Hospital firewall.

Article XIX. COMMUNICATION WITH THE BOARD

Communication between the Professional Staff and the Board occurs at least in the following manner:

- A. Through the Administrators as designees of the Board;
- B. Through the Medical Executive Committee;
- C. Through the physician Chief of Staff
- D. Through the Executive Committee of the Board

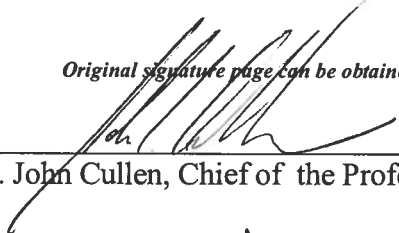
Article XX. ADOPTION

These policies and procedures shall be adopted at any regular or special meeting of the Professional Staff by a majority vote of the Members of the Active Category present and shall replace any previous policies and become effective when approved by the Board.

The Professional Staff Rules and Regulations were officially reviewed for currency.

APPROVED by the Professional Staff on 03/19/12

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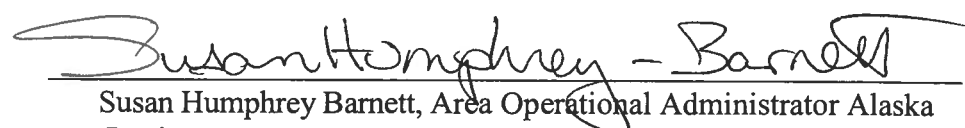

Dr. John Cullen, Chief of the Professional Staff

APPROVED by Sean McCallister on 03/19/12


Sean McCallister, PVMC Administrator

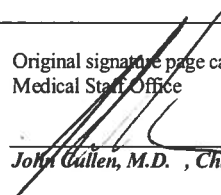
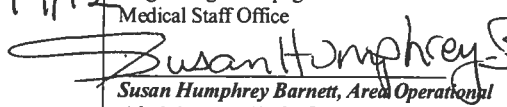
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APPROVED by Susan Humphrey Barnett on 03/19/12


Susan Humphrey Barnett, Area Operational Administrator Alaska Region

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The Professional Staff Rules and Regulations were officially reviewed and deemed current by the MEC, Active Staff Members of the Professional Staff and the Board:

<i>Review Date</i>	<i>MEC Approval</i>	<i>Medical Staff Approval Date</i>	<i>Review Date</i>	<i>Board Approval</i>
3/19/12	<p>Original signature page can be obtained in the Medical Staff Office</p>  <p><u>John Cullen, M.D. , Chief of Staff</u></p>	3/19/12	3/19/12	<p>Original signature page can be obtained in the Medical Staff Office</p>  <p><u>Susan Humphrey Barnett, Area Operational Administrator Alaska Region</u></p>

Rules and Regulations

Professional Staff Providence Valdez Medical Center

Exhibit A

Hospital Policies Pertaining to Members

Policy #	Policy Title
700.000	Physician on Call and Response Time
700.001	Credentialing Process
700.003	Expected patient Outcomes
700.004	Medical Staff Acknowledgement Statement
100.000	PRO – GOV-208 Conflict of Interest
100.009	Conduct of Care Providers
800.001	Medical Record Service
800.070	Physician Orientation to H.I.M.
800.071	Physician Signatures
800.072	Documentation Guidelines for Health Care Practitioners
800.073	Documentation Guidelines for Outpatient Services
800.186	Information Management Plan
800.188	Medical Record Abbreviations
500.012	Physician Owned Instruments/Equipment
920.07	Initial Screening Exam in the Emergency Department
PROV-MED-308	Excluded Individual Checks Medical Staff
PROV-ICP-721	Non Monetary Compensation and Medical Staff Incidental Benefit

PROV – ICP – 722 Compliance with the Code of Conduct

PROV-COMM– 604 Electronic Social Media