



MEDICAL STAFF CREDENTIALS POLICY

PROVIDENCE ALASKA MEDICAL CENTER

APPROVED by the Providence Alaska Region Board



Pam Shirrell, RN, Chair

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Final Approval at PHSA
Regional Board Meeting

Date



Lindsay Cobb, MD, Chief of Staff

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Final Approval at Medical
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MEDICAL STAFF CREDENTIALS MANUAL

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ARTICLE 1: CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.A. CONFIDENTIALITY

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

- (a) to another authorized individual and for the purpose of conducting professional review activity;
- (b) as authorized by a policy; or
- (c) as authorized by the Chief Medical Officer or by legal counsel to the Medical Center.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality shall not constitute a waiver of any privilege. Any member of the Medical Staff or the Allied Health Staff who becomes aware of a breach of confidentiality is encouraged to inform the Chief Medical Officer, or the Chief of Staff (or the Vice-Chief of Staff if the Chief of Staff is the person committing the claimed breach).

1.B. PEER REVIEW PROTECTION

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law and are deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986 (“HCQIA”), 42 U.S.C. §11101 et seq. All professional review activity will be performed by the peer review committees. Peer review committees include, but are not limited to:

- (a) all standing and ad hoc Medical Staff and Medical Center committees;
- (b) all departments;
- (c) hearing and appellate review panels;
- (d) the Board and its committees; and
- (e) any individual or body acting for or on behalf of a peer review committee, Medical Staff Leaders, and experts or consultants retained to assist in professional review activity.

ARTICLE 2: QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1 Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment or clinical privileges, an applicant must, as applicable:

- (a) have a current, unrestricted license to practice in this state that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;
- (b) have a current, unrestricted DEA registration and state controlled substance license (if applicable);

- (c) be located (office and residence) close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Medical Center;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center. The Medical Executive Committee shall have an opportunity for input into changes in coverage requests;
- (e) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (f) have never had Medical Staff or Allied Health Staff appointment, or clinical privileges denied, revoked, or terminated by any health care facility, including this Medical Center, for reasons related to clinical competence or professional conduct;
- (g) have never resigned Medical Staff or Allied Health Staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Medical Center;
- (h) have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay a civil money penalty for the same since the beginning of medical education (e.g., medical school);
- (i) have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor relating to controlled substances, illegal drugs, violent acts, sexual misconduct, moral turpitude, or child or elder abuse within the last seven years (this criterion will be interpreted in accordance with applicable law);
- (j) have an appropriate coverage arrangement, as determined by the Credentials Committee, with other members of the Medical Staff for those times when the individual will be unavailable;
- (k) document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;
- (l) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;
- (m) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;
- (n) demonstrate recent clinical activity in their primary area of practice, in an acute care hospital (or, if applying for outpatient practice only, in a similar outpatient setting) during the last two years;
- (o) have successfully completed¹:

1 These requirements will be applicable only to those individuals who apply for initial staff appointment after November 2006. Existing members will be governed by the residency training and board certification requirements in effect at the time of their initial appointment.

- (i) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or the approved Canadian or United Kingdom equivalent in the specialty in which the applicant seeks clinical privileges;
 - (ii) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;
 - (iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or
 - (iv) for professionals other than physicians, dentists or podiatrists, have satisfied the applicable training requirements as established by the Medical Center. Boards approved for certification of members of the Allied Health Staff are set forth in Appendix B.
- (p) be certified in their primary area of practice at the Medical Center by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, or the approved Canadian or United Kingdom equivalent; the American Board of Oral and Maxillofacial Surgery, the American Dental Association, or the American Board of Podiatric Surgery, as applicable, or, if not certified, be within five years from the date of completion of their residency or fellowship training, in order to be eligible for medical staff appointment;
 - (q) maintain board certification in their primary area of practice at the Medical Center and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements; or meet the Grandfather Clause as outlined in their primary area of practice. Recertification will be assessed at reappointment;
 - (r) if seeking to practice as an Advanced Practice Clinician or Dependent Provider, must have a written agreement with a Supervising/Collaborating Physician, which agreement must meet all applicable requirements of state law and Medical Center policy; and
 - (s) if employed by the Medical Center or its affiliates, maintain employment in good standing. To the extent any provision in the Bylaws, all existing Rules and Regulations, and policies of the Medical Staff conflict with terms or conditions of the employment contract, the terms and conditions of the contract shall control.

2.A.2 Extension of Time Frame to Satisfy Board Certification Criterion:

In exceptional circumstances, the five-year time frame for initial applicants to obtain certification and the time frame for recertification by existing members may be extended for one additional appointment term, not to exceed two years, in order to permit an individual an opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

- (a) the individual has been on the Medical Staff for at least three consecutive years;
- (b) there have been no documented peer review concerns related to the individual's competence or behavior at the Medical Center during the individual's tenure that have risen to the level of the involvement of the Executive Committee;

- (c) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and
- (d) the appropriate department chair provides a favorable report concerning the individual's qualifications.

2.A.3 Waiver of Threshold Eligibility Criteria:

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver must be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chair, and the best interests of the Medical Center and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee will forward its recommendation, including the basis for such, to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (c) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation. A determination to recommend a waiver must be unanimous to be forwarded to the Board.
- (d) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges because an application will not be processed. The individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

2.A.4 Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;

- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.5 No Entitlement to Appointment:

No one is entitled to receive an application, be appointed or reappointed to the Medical Staff or Allied Health Staff or be granted or exercise particular clinical privileges merely because he or she:

- (a) is employed by this Medical Center or its affiliates or has a contract with this Medical Center;
- (b) is or is not a member or employee of any particular physician group;
- (c) is licensed to practice a profession in this or any other state;
- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, Medical Staff or Allied Health Staff appointment or privileges at any hospital or health care facility;
- (f) resides in the geographic service area of the Medical Center; or
- (g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.6 Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of gender, race, creed, sexual orientation, national origin, or faith.

2.A.7 Ethical and Religious Directives:

All members will abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Medical Center. No member will engage in activity prohibited by the Directives at the Medical Center. A copy of the Directives shall be made available to every applicant.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1 Basic Responsibilities and Requirements: As a condition of being granted appointment or reappointment and as a condition of ongoing appointment, every individual specifically agrees to the following:

- (a) to provide continuous and timely care;
- (b) to abide by the bylaws, policies, and rules and regulations of the Medical Center and Medical Staff and any revisions or amendments thereto;

- (c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;
- (d) to provide emergency call coverage, consultations, and care for unassigned patients;
- (e) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the Medical Executive Committee or document the clinical reasons for variance;
- (f) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy;
- (g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
- (h) to use the Medical Center sufficiently to allow continuing assessment of current competence;
- (i) to seek consultation whenever necessary;
- (j) to complete in a timely manner all medical and other required records;
- (k) to perform all services and to act in a cooperative and professional manner;
- (l) to promptly pay any applicable dues, assessments, or fines;
- (m) to utilize the Medical Center's electronic medical record system;
- (n) to satisfy continuing medical education requirements;
- (o) to attend and participate in any applicable orientation programs at the Medical Center within the time period established by policy;
- (p) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (q) to maintain a current e-mail address with the Medical Staff Office, which will be the primary mechanism used to communicate all Medical Staff or Allied Health Staff information to the member;
- (r) to cooperate, as applicable, with the Tumor Registry;
- (s) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Medical Center or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Medical Center that a Medical Staff member may request the Medical Center to purchase;
- (t) that, if the individual is a member of the Medical Staff who serves or plans to serve as a Supervising Physician to an Advanced Practice Clinician, Certified Nurse Midwife, or Dependent Provider, that the

member of the Medical Staff will abide by the supervision requirements and conditions of practice set forth in Article 11; and

- (u) that, if the individual is an Advanced Practice Clinician, Certified Nurse Midwife, or Dependent Provider, he or she will abide by the conditions of practice set forth in Article 11.

2.B.2 Burden of Providing Information:

- (a) All applicants and members have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.
- (b) Applicants have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application are accurate and complete.
- (c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.
- (d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- (e) Applications that are considered incomplete will deem the applicant ineligible to reapply for a period of two years or greater. Applicants may submit a request for waiver of the requirement, which will be processed in the same manner as a waiver of threshold eligibility criteria.
- (f) Applicants and members are responsible for notifying the Chief of Staff or the Medical Staff Office of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but not be limited to:
 - (i) any information on the application form;
 - (ii) any threshold eligibility criteria for appointment or clinical privileges;
 - (iii) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization,
 - (iv) changes in professional liability insurance coverage;
 - (v) the filing of a professional liability lawsuit against the practitioner;
 - (vi) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;
 - (vii) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same;
 - (viii) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health); and
 - (ix) any investigations, complaints, disciplinary actions, counseling, or other Human Resources actions if employed by the Medical Center or its affiliates.

2.C. APPLICATION

2.C.1 Information:

- (a) Application forms (which may be electronic) for appointment, reappointment, and clinical privileges will be approved by the Board, upon recommendation by the Credentials Committee and the Medical Executive Committee.
- (b) The applications for initial appointment, reappointment, and clinical privileges existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (c) The application will contain a request for specific clinical privileges, if applicable, and will require detailed information concerning the applicant's professional qualifications. The applicant will sign the application (by electronic signature) and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2 Misstatements and Omissions:

- (a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief of Staff and the Chair of the Credentials Committee in consultation with Chief Medical Officer (if applicable) will review the response and determine whether the application should be processed further.
- (b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to this Policy.
- (c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

2.C.3 Grant of Immunity and Authorization to Obtain/Release Information:

- (a) Conditions Prerequisite to Application and Consideration: As a condition of having a request for application considered or applying for appointment, reappointment, clinical privileges, or a scope of practice, every individual accepts the terms set forth in this Section.
- (b) Scope of Conditions: The terms set forth in this Section:
 - (i) commence with the individual's initial contact with the Medical Center, whether an application is furnished or appointment, clinical privileges, or scope of practice are granted;
 - (ii) apply throughout the credentialing process and the term of any appointment, reappointment, clinical privileges, or scope of practice; and
 - (iii) survive for all time, even if appointment, reappointment, clinical privileges, or scope of practice is denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Medical Center's professional review activities and even if the individual no longer maintains appointment, clinical privileges or a scope of practice at the Medical Center.
- (c) Use and Disclosure of Information about Individuals:
 - (i) Information Defined. For purposes of this Section, "information" means information about the individual, regardless of the form (which shall include verbal, electronic, and paper), which

pertains to the individual's appointment, reappointment, clinical privileges, or scope of practice, or the individual's qualifications for the same, including, but not limited to:

- information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without accommodation;
 - any matter addressed on the application form or in the Medical Staff Bylaws, Credentials Policy, and other Medical Center or Medical Staff policies and rules and regulations;
 - any reports about the individual which are made by the Medical Center, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and
 - any references received or given about the individual.
- (ii) Authorization for Criminal Background Check. The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Medical Center.
- (iii) Authorization to Share Information within the System. The individual authorizes the Medical Center and its affiliates within the Providence Health & Services System to share information with one another.
- (iv) Authorization to Obtain Information from Third Parties. The individual authorizes the Medical Center, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Medical Center.
- (v) Authorization to Disclose Information to Third Parties. The individual authorizes the Medical Center, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.
- (d) Hearing and Appeal Procedures: The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.
- (e) Immunity: To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Medical Center, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, Allied Health Staff, or Board, and any third party who provides information.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Medical Center, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

ARTICLE 3: PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1 Application:

- (a) Applications for appointment and/or clinical privileges will be on forms approved by the Board, upon recommendation of the Credentials Committee and the Medical Executive Committee.
- (b) Prospective applicants will be sent the application form for appointment and the applicable criteria for clinical privileges.
- (c) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2 Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 45 days after receipt. Membership and/or clinical privileges will not be granted until the application fee is received.
- (b) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.
- (c) The Medical Staff Office will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.
- (d) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chair at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank will be queried as required.
- (e) An interview(s) with the applicant will be conducted, if requested. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted by one or any combination of any of the following: the department chair, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the Chief of Staff or the Chief Medical Officer.

3.A.3 Department Chair Procedure:

The Medical Staff Office will transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges (removable, to the Chief of Staff). The department chair will prepare a written report regarding whether the applicant has satisfied all of the

qualifications for appointment and/or the clinical privileges requested. The report will be on a form provided by the Medical Staff Office.

3.A.4 Temporary “Interim” Privileges:

A complete application for Medical Staff or Allied Health Professionals Staff privileges may be considered for interim privileges, as described in Section 4.B Temporary Privileges, and in the MS 900-007 Disposition of Applications Policy.

3.A.5 Credentials Committee Procedure:

- (a) The Credentials Committee will consider the report prepared by the department chair(s) and will make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chair(s), or any member of the department, or an outside consultant, if additional information is required regarding the applicant’s qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and/or privileges, if there is any question about the applicant’s ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation within a reasonable time as determined by the Credentials Committee by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee. Failure to undergo fitness for practice evaluation within a reasonable time after a written request from the Credentials Committee will be considered a voluntary withdrawal of the application.
- (d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment and/or privileges be granted for a period of less than two years in order to permit closer monitoring of the applicant’s compliance with any conditions.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chair of the Credentials Committee will send a letter to the applicant, with a copy to the Chief Medical Officer, explaining the reasons for the delay.

3.A.6 Medical Executive Committee Recommendation:

- (a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the Medical Executive Committee will:
 - (i) adopt the report and recommendation of the Credentials Committee as its own; or
 - (ii) refer the matter back to the Credentials Committee for further consideration of specific questions; or
 - (iii) state its reasons for disagreement with the report and recommendation of the Credentials Committee.
- (b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board.

- (c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the Chief Medical Officer, who will promptly send special notice to the applicant. The Chief Medical Officer will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7 Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:
 - (i) a current or previously successful challenge to any license or registration;
 - (ii) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - (iii) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint will be effective immediately and will be forwarded to the Board for consideration at its next meeting.

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
 - (i) grant appointment and clinical privileges as recommended; or
 - (ii) refer the matter back to the Credentials Committee or Executive Committee or to another source for additional research or information; or
 - (iii) modify the recommendation.
- (c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chair of the Credentials Committee and the chair of the Medical Executive Committee. If the Board's determination remains unfavorable, the Chief Medical Officer will promptly send special notice that the applicant is entitled to request a hearing
- (d) Any final decision by the Board to grant, deny, modify, or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8 Time Periods for Processing: Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

3.A.9 External Proctor Authorization Process:

- (a) External Proctor authorization may be granted by the medical staff leaders referenced below to visit PAMC for the purpose of proctoring a member performing a new privilege, or a procedure with the use of new technology, when no medical staff member has the necessary expertise. The decision as to whether to grant external proctor authorization shall be in the sole discretion of the medical staff leaders referenced below in subsection (e).

- (b) External Proctors may include: 1. a device manufacturer trainer who has been thoroughly trained as required by the manufacturer 2. a physician or physician team as sponsored by said device manufacturer 3. a qualified physician, outside of PAMC, who has recognized expertise in said procedure
- (c) External proctors are not granted clinical privileges and may not admit, treat, examine, consult, write or give verbal orders, perform or assist (except verbally) with procedures, write in the medical record, or otherwise participate directly in the care of any patient. They shall not be members of the Medical Staff and shall not have access to any of the rights or prerogatives of membership, but shall abide by all applicable hospital and Medical Staff Bylaws, Rules and Regulations and other governance documents.
- (d) The External Proctor application form and all required documentation will be forwarded to the medical staff office at least 10 business days prior to the procedure to be proctored. Documentation and verifications required prior to authorization include:
 - (i) Request from current medical staff member for the External Proctor
 - (ii) Consent and Release of Information
 - (iii) Proctor Application
 - (iv) Confidentiality Form
 - (v) Current CV
 - (vi) Letter submitted directly to PAMC from the proposed proctor's primary practice facility indicating he/she is currently in good standing, possess the clinical privileges to perform the procedures for which he/she wish to proctor the member of the medical staff, and that he/she has successfully performed a minimum number (as determined by the Department Chair) of the procedures that he/she will be proctoring at PAMC
 - (vii) Evidence that demonstrates current clinical competence and overall qualifications to perform the privileges in question
 - (viii) If sponsored by a vendor, documentation from the vendor indicating you are an approved proctor
 - (ix) Copy of government issued ID
 - (x) NPDB report (Medical Staff Services will obtain)
 - (xi) Verification of licensure (Medical Staff Services will obtain)
- (e) No External Proctor authorization may be granted in cases in which the Proctor Guidelines of the Medical Staff and the credentialing criteria are not met.
- (f) External Proctor authorization may be granted for up to one (1) year upon the concurrence of the affected Department/Section Chairperson, the Chairman of the Credentials Committee, and the President of the Medical Staff, or their designees, each of whom must be satisfied as to the qualifications of the Member's applicant for such privileges and as to the need for proctoring.
- (g) External Proctor authorization shall be granted through the issuance of a written delineation form which shall describe in reasonable detail the scope and duration of the authorization being granted.
- (h) External Proctors must report to the Medical Staff Office upon arrival to PAMC for identity verification and issuance of a proctor badge.
- (i) Fees charged by the Proctoring Physician will be the responsibility of the Physician requesting External Proctor authorization.

ARTICLE 4: CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1 General:

- (a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Medical Center. Only those clinical privileges granted by the Board may be exercised, subject to the terms of this Policy.
- (b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived in accordance with the applicable sections of this Policy.
- (c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract.
- (d) Recommendations for clinical privileges will be based on consideration of the following:
 - (i) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (ii) appropriateness of utilization patterns;
 - (iii) ability to perform the privileges requested competently and safely;
 - (iv) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (v) availability of coverage in case of the applicant's illness or unavailability;
 - (vi) adequate professional liability insurance coverage for the clinical privileges requested;
 - (vii) the Medical Center's available resources and personnel;
 - (viii) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (ix) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (x) practitioner-specific data as compared to aggregate data, when available;
 - (xi) morbidity and mortality data, when available; and
 - (xii) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.
- (e) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

4.A.2 Privilege Waivers:

- (a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)

- (b) In limited circumstances, the Medical Center may consider a waiver of the requirement that clinical privileges be granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Medical Staff Office. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.
- (c) Requests for waivers will be processed in the same manner as requests for waivers of appointment criteria.
- (d) The following factors, among others, may be considered in deciding whether to grant a waiver:
 - (i) the Medical Center's mission and ability to serve the health care needs of the community by providing timely, appropriate care;
 - (ii) the effect of the request on the Medical Center's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;
 - (iii) the expectations of members who rely on the specialty;
 - (iv) fairness to the individual requesting the waiver;
 - (v) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and
 - (vi) the potential removal for gaps in call coverage that might result from an individual's from the call roster and the feasibility of safely transferring patients to other facilities.
- (e) If the Board grants a waiver related to privileges, it will specify the effective date.
- (f) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

4.A.3 Relinquishment of Individual Clinical Privileges:

A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of clinical privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

4.A.4 Resignation of Appointment and Clinical Privileges:

A request to resign all clinical privileges must (a) specify the desired date of resignation, at least 30 days from the date of the request, and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the Chief of Staff, the Chief Medical Officer will act on the request.

4.A.5 Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Medical Center or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Medical Center and criteria for the clinical privilege(s) have been adopted.
- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chair and the Credentials Committee addressing the following:

- (i) minimum education, training, and experience necessary to perform the new procedure safely and competently;
- (ii) clinical indications for when the new procedure is appropriate;
- (iii) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
- (iv) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
- (v) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
- (vi) whether the Medical Center currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The department chair and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Medical Center.

- (c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:
 - (i) the minimum education, training, and experience necessary to perform the procedure or service;
 - (ii) the clinical indications for when the procedure or service is appropriate;
 - (iii) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and
 - (iv) the manner in which the procedure would be reviewed as part of the Medical Center's ongoing and focused professional practice evaluation activities.
- (d) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.6 Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.
- (b) As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.
- (c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Medical Center (e.g., other hospitals, residency training programs, specialty societies).

- (d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If it does, the Committee may develop recommendations regarding:
 - (i) the minimum education, training, and experience necessary to perform the clinical privileges in question;
 - (ii) the clinical indications for when the procedure is appropriate;
 - (iii) the manner of addressing the most common complications that arise, which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (iv) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
 - (v) the manner in which the procedure would be reviewed as part of the Medical Center's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
 - (vi) the impact, if any, on emergency call responsibilities.
- (e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.7 Practitioners in Training:

Practitioners in training will not be granted appointment to the Medical Staff nor clinical privileges pertaining to their training. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the Medical Executive Committee or its designee, and the Graduate Medical Education Committee of the Medical Center. The Medical Staff Office will be responsible for verifying the qualifications of each practitioner in training. Fellows who seek clinical privileges outside of the scope of their training program will be subject to applicable criteria for privileges.

4.A.8 Telemedicine Privileges:

- (a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.
- (b) A qualified individual may be granted telemedicine privileges, but need not be appointed to the Medical Staff or Allied Health Staff. All individuals considered for telemedicine privileges must provide evidence of adequate insurance coverage, which may be through a separate rider.
- (c) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the Chief Medical Officer in consultation with the Chief of Staff:
 - (i) A request for telemedicine privileges may be processed through the same process for Medical Staff and Allied Health Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.
 - (ii) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity is accredited by the Joint Commission, a request for telemedicine

privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Medical Center must ensure, through a written agreement that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

- confirmation that the practitioner is licensed in the state where the Medical Center is located;
- a current list of privileges granted to the practitioner;
- information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;
- a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;
- a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and
- any other attestations or information required by the agreement or requested by the Medical Center.

This information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this subsection, the Medical Center may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

- (d) Telemedicine privileges, if granted, will be for a period of not more than two years.
- (e) Individuals granted telemedicine privileges will be subject to the Medical Center's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.
- (f) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

4.A.9 Focused Professional Practice Evaluation for Initial Privileges:

- (a) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused professional practice evaluation by the department chair or by a physician(s) designated by the Credentials Committee.
- (b) This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the Credentials Committee.
- (c) A newly appointed member's appointment and privileges will expire if he or she fails to fulfill the clinical activity requirements within the time frame recommended by the Credentials Committee. In such case, the individual may not reapply for initial appointment or privileges for two years.

- (d) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame recommended by the Credentials Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for two years.
- (e) When, based upon information obtained through the focused professional practice evaluation process, a recommendation is made to terminate, revoke, or restrict clinical privileges for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

4.B. TEMPORARY PRIVILEGES

Interim Privileges may be granted when an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the governing body. The Medical Center defines this type of temporary privileges as “interim” privileges merely for distinction. The MS 900-007 Disposition of Applications Policy outlines the requirements for an application to be deemed complete and eligible for interim consideration. Interim privileges may be used for initial applicants, requests for additional privileges out of the reappointment cycle, and requests for additional privileges during reappointment. Interim privileges remain in effect not to exceed 120 days. The Medical Staff President and Chief Executive Officer authorize a member of the Credentials Committee to recommend and grant interim privileges.

Temporary Privileges may also be granted to an appropriately licensed practitioner, on a case-by-case basis, when an important patient care need mandates an immediate authorization to practice for a limited period of time. Temporary privileges shall be granted for a specified time, and may not be granted in excess of 120 days, except in the case of patient specific privileges. The Medical Staff President and Chief Executive Officer authorize a member of the Credentials Committee to recommend and grant temporary privileges. Temporary privileges may be granted when:

- (a) The Chief Executive Officer, or designee, may grant temporary privileges upon the recommendation of the Chief of Staff or Chief Medical Officer, if there is verification of:
 - (i) Current copies of CV, malpractice insurance, completed application, government ID
 - (ii) Criminal background check
 - (iii) Current licensure, board certification and DEA if applicable; with no current or previously successful challenge to such license or registration
 - (iv) Relevant training; via a query and evaluation of the AMA and certifying board, or other applicable entity
 - (v) Current competence and ability to perform privileges requested; via patient logs, CME, a fully positive peer reference, and query of current primary hospital affiliation
 - (vi) A query and evaluation of the National Practitioner Data Bank (NPDB) information to determine;
 - No subjection to involuntary termination of medical staff membership at another organization, and
 - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
 - Medical malpractice claims

Definitions:

- (b) Patient Specific: A practitioner has provided patient care services to a specific patient prior to admission to the Hospital and the patient continues to require medical and/or post-operative follow-up care from the specific practitioner while an inpatient at the Hospital. Privileges for a specific patient will remain in effect throughout the patient’s procedure or hospitalization, as applicable.

- (c) To prevent a lack or lapse of services: Due to acuity of care that current medical staff members cannot safely manage, or because there is an inadequate number of other specialists on staff to prevent a lack or lapse in services.
- (d) Temporary privileges will not be granted due to a practitioner's failure to apply for privileges in a timely manner.

Special requirements of supervision and reporting may be imposed by the Chief Executive Officer, Medical Staff President or Chief Medical Officer on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer, or designee, upon notice of any failure by the practitioner to comply with such special conditions. Denial or termination of temporary privileges shall not give the affected practitioner any right to a hearing or appeal.

4.C. EMERGENCY SITUATIONS

- (a) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.
- (b) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (c) When the emergency situation no longer exists, the patient will be assigned by the department chair or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES – See Medical Staff Bylaws

4.E. CONTRACTS FOR SERVICES

- (a) From time to time, the Medical Center may enter into contracts or arrangements with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Medical Center. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Medical Center, in accordance with the terms of this Policy.
- (b) To the extent that:
 - (i) any such contract or arrangement confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or
 - (ii) the Board by resolution or other arrangement limits the practitioners who may exercise clinical privileges in any clinical specialty to employees of the Medical Center or its affiliates,
 - (iii) no other practitioner except those authorized by or pursuant to the contract or arrangement may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners so authorized are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

ARTICLE 5: PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment.

5.B. REAPPOINTMENT CRITERIA

5.B.1 Eligibility for Reappointment: To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- (a) completed all medical records;
- (b) completed all continuing medical education requirements;
- (c) satisfied all Medical Staff and Allied Health Staff responsibilities, including payment of any dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) paid any applicable reappointment processing fee;
- (f) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Medical Center must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application will be considered complete and processed further; and
- (g) if employed by the Medical Center or its affiliates, maintained employment in good standing.

5.B.2 Factors for Evaluation: In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

- (a) compliance with the bylaws, rules and regulations, and policies of the Medical Staff and the Medical Center;
- (b) participation in Medical Staff duties, including committee assignments and emergency call;
- (c) the results of the Medical Center's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients or staff; and
- (f) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1 Reappointment Application Form:

- (a) Appointment terms will not extend beyond two years.
- (b) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 45 days.
- (c) Failure to return a completed application within 45 days will result in the assessment of a reappointment processing fee. Failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.
- (d) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (e) The Medical Staff Office will oversee the process of gathering and verifying relevant information. The Medical Staff Office will also be responsible for confirming that all relevant information has been received.

5.C.2 Conditional Reappointments:

- (a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements).

5.C.3 Shortened Reappointment Period:

- (a) Reappointments may be recommended for periods of less than two years in order to permit closer review of a member's practice or behavior.
- (b) In the event the applicant for reappointment is the subject of an investigation or a peer review process at the time reappointment is being considered, a reappointment for a period of less than two years may be granted pending the completion of that process.
- (c) A recommendation of a reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

5.C.4 Potential Adverse Recommendation:

- (a) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce, restrict or condition clinical privileges, the committee chair shall notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.

- (b) Prior to this meeting, the member shall be notified of the general nature of the information supporting the recommendation contemplated.
- (c) At the meeting, the member shall be invited to discuss, explain, or refute this information. A summary of the interview shall be made and included with the committee's recommendation.
- (d) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The member shall not have the right to be represented by legal counsel at this meeting.

ARTICLE 6: QUESTIONS INVOLVING MEDICAL STAFF OR ALLIED HEALTH STAFF MEMBERS

6.A. OVERVIEW AND GENERAL PRINCIPLES

This policy addresses the approach of the Providence Alaska Medical Center (PAMC) medical staff regarding the investigation, hearing and appeals process for any member from any department of the Medical Staff, Allied Health Professional Staff, the Clinical Staff or an applicant to one of the prior categories, if properly requested and if applicable.

6.A.1 Definitions:

The following definitions apply to the provisions of this Investigation, Hearing & Appeals Plan.

- (a) "**Administrator**" refers to the Administrator of Providence Alaska Medical Center, who acts on behalf of the board.
- (b) "**Appellate Review Committee**" refers to the group designated under this Plan to hear an appeal properly requested by a practitioner.
- (c) "**Applicant**" refers to a physician, dentist, podiatrist, allied health professional or clinical staff that applies to the Medical Staff or the Allied Health Professional Staff at Providence Alaska Medical Center.
- (d) "**Board**" refers to the Providence Health & Services Alaska Community Ministry Board.
- (e) "**Business Day**" refers to Monday through Friday, excluding PAMC employee holidays.
- (f) "**Hearing Committee**" refers to the committee appointed under this Plan to preside over an evidentiary hearing properly requested by a practitioner or applicant.
- (g) "**MEC**" refers to the Medical Executive Committee.
- (h) "**Party**" or "**Parties**" refers to the practitioner or applicant who requested the hearing or appellate review and the body or bodies who participate in the hearing or appellate review.
- (i) "**Practitioner**" refers to the Medical Staff member as defined in the Bylaws or Allied Health Professional (AHP) and Clinical Staff as defined in the Allied Health Professionals Credentials Manual.
- (j) "**Referral Back**" or "**Refer Back**" refers to the process whereby the Service Area Chief Executive, 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.

- (k) "**Special Notice**" refers to written notification sent by certified or registered mail, return receipt requested.

6.A.2 Options Available to Medical Staff Leaders and Administration:

- (a) This Policy empowers Medical Staff Leaders and Medical Center Administration to use various options to address and resolve questions that may be raised about members of the Medical Staff and the Allied Health Staff. The various options available to Medical Staff Leaders and Medical Center Administration and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:
 - (i) collegial intervention and progressive steps;
 - (ii) ongoing and focused professional practice evaluations;
 - (iii) mandatory meeting;
 - (iv) fitness for practice evaluation (including blood and/or urine test);
 - (v) automatic relinquishment of appointment and clinical privileges;
 - (vi) leaves of absence;
 - (vii) precautionary suspension; and
 - (viii) formal investigation.
- (b) In addition to these options, Medical Staff Leaders and Medical Center Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Medical Executive Committee for further action.

6.A.3 Documentation:

- (a) Except as otherwise expressly provided, Medical Staff Leaders and Medical Center Administration may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.
- (b) Any documentation that is prepared will be shared with the individual. The individual will have an opportunity to review the documentation and respond to it. The initial documentation, along with any response, will be maintained in the individual's confidential file.

6.A.4 No Recordings of Meetings:

It is the policy of the Medical Center to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the Chief Medical Officer.

6.A.5 No Right to Counsel:

- (a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers **will not** be present for any meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and Chief Medical Officer, an exception may be made to this general rule.
- (b) If the individual refuses to meet without his or her lawyer present, the applicable leaders may ask the individual to submit written responses to written questions.

6.A.6 No Right to the Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article.

6.A.7 Involvement of Supervising Physician in Matters Pertaining to Allied Health Staff Members:

If any peer review activity pertains to the clinical competence or professional conduct of a member of the Allied Health Staff, the Supervising Physician (if any) will be notified and may be invited to participate.

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

- (a) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and Medical Center Administration is encouraged.
- (b) The goal of those efforts is to arrive at voluntary, responsive actions by the individual to resolve an issue that has been raised. Collegial efforts and progressive steps may be carried out, within the discretion of Medical Staff Leaders and Medical Center Administration, but are not mandatory.
- (c) Collegial intervention efforts and progressive steps are part of the Medical Center's ongoing and focused professional practice evaluation activities and may include, but are not limited to, the following:
 - (i) sharing and discussing applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
 - (ii) counseling, mentoring, monitoring, proctoring, consultation, and education;
 - (iii) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;
 - (iv) communicating expectations for professionalism and behaviors that promote a culture of safety;
 - (v) informational letters of guidance, education, or counseling; and
 - (vi) Performance Improvement Plans.

6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

- (a) Individuals who are initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation to confirm their competence.

- (b) All individuals who provide patient care services at the Medical Center will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.
- (c) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

6.D. MANDATORY MEETING

- (a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff Leaders may require the individual to attend a mandatory meeting.
- (b) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.
- (c) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth below.

6.E. FITNESS FOR PRACTICE EVALUATION

- (a) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a complete fitness for practice evaluation to determine his or her ability to safely practice.
- (b) A request for an evaluation may be made of an applicant during the initial appointment or reappointment processes or of a member during an investigation. A request for an evaluation may also be made when at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Medical Center Administration) are concerned with the individual's ability to safely and competently care for patients.
- (c) The Medical Staff Leaders or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.
- (d) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges as set forth below.

6.F. LEAVES OF ABSENCE

6.F.1 Initiation:

- (a) A leave of absence of up to one year (to include a sabbatical) must be requested in writing and submitted to the Chief of Staff or the Medical Staff Office. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave; active duty military service or

National Guard Reserves members who are deployed for service are not required to provide 30 days prior notice.

- (b) The Chief Medical Officer will determine whether a request for a leave of absence will be granted, after consulting with the Chief of Staff and the relevant department chair. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.
- (c) Members of the Medical Staff or Allied Health Staff must report to the Chief Medical Officer any time they are away from Medical Staff, Allied Health Staff, or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the Chief Medical Officer, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.
- (d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

6.F.2 Duties of Member on Leave:

During a leave of absence, the individual will not exercise any clinical privileges and will be excused from Medical Staff and Allied Health Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay dues and complete a reappointment application, if applicable, will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

6.F.3 Reinstatement:

- (a) Individuals requesting reinstatement (other than those whose leave was due to military service) will submit a written summary of their professional activities during the leave and any other information that may be requested by the Medical Center. Requests for reinstatement will then be reviewed by the relevant department chair, the chair of the Credentials Committee, the Chief of Staff and the Chief Medical Officer.
- (b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board.
- (c) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- (d) Absence for longer than one year will result in resignation of Medical Staff or Allied Health Staff appointment and clinical privileges unless an extension is granted by the Chief Medical Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Center.

- (e) If an individual's current appointment is due to expire during the leave, the individual must complete their reappointment but will remain on a Leave of Absence until reinstatement is approved.

ARTICLE 7: INVESTIGATIONS AND FORMAL PEER REVIEW ACTION

7.A. CRITERIA FOR INITIATION OF FORMAL CORRECTIVE ACTION

A formal peer review action investigation may be initiated whenever reliable information indicates a member may have exhibited acts, demeanor or conduct, either within or outside of the hospital that is reasonably likely to be

- (a) Detrimental to patient safety or to the delivery of quality patient care within the hospital;
- (b) Unethical;
- (c) Contrary to the medical staff bylaws, policies or rules and regulations;
- (d) Below applicable professional standards;
- (e) Disruptive of medical staff or hospital operations; or
- (f) An improper use of hospital resources.

Generally, formal peer review action measures should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal peer review action may be initiated whenever circumstances reasonably appear to warrant formal action.

7.B. INITIATION

Any person who believes that a review may be warranted may provide information to the Chief of the Medical Staff, the Chief Medical Officer, or a hospital administrator, or their designee.

If any of the above-named person(s) determines that an investigation is deemed appropriate, that person may suggest the initiation of a formal investigation or may recommend particular corrective action. Such requests must be conveyed to the Chief of Staff and if he/she concurs, the MEC must be informed.

The Chief of Staff shall notify the Administrator or his or her designee in his or her absence and the MEC and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any investigation, provided, however, that the Chief of Staff or the MEC may dispense with further investigation of matters deemed to have been adequately investigated by a committee or designated individual.

7.C. EXPEDITED INITIAL REVIEW

Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee may, on behalf of the MEC, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the MEC, which shall decide whether to initiate a corrective action investigation.

In cases of complaints of harassment or discrimination the Chief of Staff, Department Chair, and the Chief Medical Officer or their designee shall conduct an expedited initial review on behalf of the MEC. An attorney may be involved in the review. The Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be referred to the MEC if it is determined that corrective action may be recommended in order to promote patient safety and performance improvement.

7.D. FORMAL INVESTIGATION

If the MEC concludes action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation.

If the MEC concludes a formal investigation is warranted, it shall direct an investigation be undertaken. The MEC may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee to be appointed by the Chief of Staff. The investigating body should not include partners, associates or relatives of the individual being investigated. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances (e.g., to help assure an unbiased review, to firm up an uncertain or controversial review or to engage specialized expertise). If the investigation is delegated to an officer or committee other than the MEC, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action.

Prior to any adverse action being approved, the MEC shall assure that the practitioner was given an opportunity to provide information in a manner and upon such terms as the MEC, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body must make reasonable attempts to obtain the facts of the matter from primary sources, and must provide the affected practitioner the opportunity to meet with the investigating committee after first having been informed generally of the questions at issue. The committee must also interview other individuals who, in the discretion of the committee, may have relevant information. The investigating committee must have a reasonable belief that the action was warranted by the facts known after such reasonable attempt to obtain the facts. Interviews in this manner, however, shall not constitute a hearing nor shall the hearings or appeals rules apply.

Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including precautionary action.

7.E. MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the MEC shall take action that may include, without limitation:

- (a) Determining no corrective action be taken and, if the MEC determines there was no credible evidence for the report in the first instance, clearly documenting those findings in the member's file.
- (b) Deferring action for a reasonable time where circumstances warrant.
- (c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the practitioner may make a written response, which shall be placed in the practitioner's confidential peer review file.
- (d) Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.
- (e) Recommending reduction, modification, suspension or revocation of clinical privileges.

- (f) Recommending reductions of medical staff, AHP or Clinical Staff membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.
- (g) Recommending suspension, revocation or probation of medical staff, AHP, or Clinical Staff membership.
- (h) Directing that the matter be handled pursuant to another policy (such as the code of conduct policy, practitioner wellness policy, and professional practice evaluation policy), or to proceed in another manner.
- (i) Requesting that the practitioner involved obtain a fitness for duty evaluation as part of the investigation process, outlining the basis for utilizing an outside consultant.
- (j) Taking other actions deemed appropriate under the circumstances.

7.F. SUBSEQUENT ACTION

If the MEC determines that no corrective action is required or that a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Board. The Board may affirm, reject or modify the action. The Board shall give great weight to the MEC's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MEC and the MEC still has not acted. The decision shall become final if the Board affirms it or takes no action on it within 90 days after receiving the MEC's decision. If the MEC recommends an action that is grounds for a hearing, the practitioner shall be given notice of the adverse recommendation and of the right to request a hearing. The Board may be informed of the recommendation, but shall take no action until the practitioner has either waived his or her right to a hearing or completed the hearing.

7.G. INITIATION BY THE BOARD

If the MEC fails to investigate or take corrective action, contrary to the weight of the evidence, the Board may direct the MEC to initiate investigation or corrective action, but only if such action is taken in a reasonable manner and after consultation with the MEC. If the MEC fails to take action in response to the direction of the Board, the Board may initiate corrective action following written notice to the MEC, but this corrective action must comply with the following sections related to hearing and appeals.

ARTICLE 8: GROUNDS FOR PRECAUTIONARY SUSPENSION OR RESTRICTION

8.A. IMPOSITION ANY TWO OF THE FOLLOWING:

1. The Chief of Staff;
2. The practitioner's respective Department Chair,
3. The Administrator,
4. The Chief Medical Officer, or;
5. The Chairman of the Board

shall have the authority to offer to the involved practitioner the opportunity to voluntarily refrain from exercising privileges pending an investigation, or to precautionary suspend or restrict all or any portion of the clinical privileges of a practitioner whenever failure to take such action may result in imminent danger to the health and/or safety of any individual. Such precautionary suspension or restriction shall become effective immediately upon

imposition. The practitioner placed on precautionary suspension will be required to find coverage for any of their suspended activities. If hospital inpatient privileges are involved in the suspension, then current hospital patients of the suspended practitioner need to be covered by a practitioner in good standing with the same delineated privileges.

Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff, or responsible Department Chair, shall have responsibility to provide for alternative medical coverage for the suspended practitioner's patients that are still in the Medical Center. The wishes of the patient and the practitioner under suspension shall be considered in the selection of such alternative coverage.

Notice of the precautionary suspension shall promptly be forwarded to the MEC, to the Administrator, and, by hand delivery, or certified mail, return receipt requested, to the affected practitioner. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended practitioner, but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

8.B. ACTION BY MEDICAL EXECUTIVE COMMITTEE

The MEC, within seven business days of a precautionary suspension, shall recommend continuance, modification, or termination of the terms of the precautionary suspension, and shall promptly notify the Administrator of its action, with similar notice to the practitioner by hand delivery, or certified mail, return receipt requested.

If the MEC recommends to continue or to continue as modified, the terms of the precautionary suspension as recommended or as modified by the MEC shall remain in effect pending a decision thereon by the Board.

If for any reason the MEC terminates the suspension or does not make a disposition within seven business days of a precautionary suspension, the suspended privileges shall automatically be reinstated.

The recommendation of the MEC to continue or to continue as modified the precautionary suspension is not a completed professional review action, and thus does not entitle the practitioner to a hearing under Article 10.

8.C. ACTION BY BOARD

Within seven business days after receipt of the recommendation of the MEC for continuance or modification of the precautionary suspension, the Board, acting through the Administrator, shall act thereon. Such action may be to affirm, to modify by increasing or reducing the discipline recommended, or to reject the recommendation.

If the board rejects the recommendation for a precautionary suspension or does not make a disposition within seven business days of the decision from the MEC, the suspended privileges shall automatically be reinstated.

The Administrator acting on behalf of the board shall notify the MEC of its recommendation, and, by hand delivery, or certified mail, return receipt requested, to the affected practitioner of the action.

The practitioner is not entitled to a fair hearing at this time in the process unless the suspension continues for more than 14 days; as such a precautionary suspension is not a final action and is pending the outcome of an investigation.

ARTICLE 9: AUTOMATIC RELINQUISHMENT

9.A. IMPOSITION OF AUTOMATIC RELINQUISHMENT

Automatic relinquishment of clinical privileges and medical staff membership shall occur whenever any of the following events occurs, effective as of the time it occurs. Hearing and appellate review rights do not apply to the imposition of automatic relinquishment.

9.A.1 State License:

- (a) **Revocation:** When a practitioner's license to practice in the state of Alaska is revoked, there is immediate and automatic revocation of appointment and all clinical privileges as of the date such action becomes effective. If the practitioner serves in a leadership capacity (Medical Staff leader / Committee Chair / Department Chair, etc.) his or her leadership position shall be automatically terminated. Upon reinstatement of the practitioner's license to practice, he or she must apply for Medical Staff appointment and clinical privileges. Application will require completion of a medical staff application in addition to a new clinical privilege list. No application fees will be imposed with this application. The application will not be accepted until the practitioner's Alaska state license has been reinstated.
- (b) **Restriction:** During the period in which a practitioner's license is partially limited or restricted in any way, those clinical privileges that he or she has been granted that are 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. If the practitioner serves in a leadership capacity (Medical Staff leader / Committee Chair / Department Chair, etc.) his or her leadership position shall be automatically terminated. Upon reinstatement of the practitioner's license to practice without such restrictions or limitations, he or she must apply for those clinical privileges that were limited or restricted. Application of clinical privileges will require completion of a medical staff application in addition to a new clinical privilege list. No application fees will be imposed with this application. The application will not be accepted until the practitioner's Alaska state license has been reinstated.
- (c) **Suspension:** If a license is suspended, the practitioner's appointment and clinical privileges are automatically suspended as of the date such action becomes effective. If the practitioner serves in a leadership capacity (Medical Staff leader / Committee Chair / Department Chair, etc.) his or her leadership position shall be automatically terminated. Upon reinstatement of the practitioner's license to practice without such restrictions or limitations, he or she must apply for those clinical privileges that were limited or restricted. Application of clinical privileges will require completion of a medical staff application in addition to a new clinical privilege list. No application fees will be imposed with this application. The application will not be accepted until the practitioner's Alaska state license has been reinstated.
- (d) **Probation:** If a practitioner is placed on probation by the relevant licensing authority, his or her membership status 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. If the practitioner serves in a leadership capacity (Medical Staff leader / Committee Chair / Department Chair, etc.) his or her leadership position shall be automatically terminated. Upon termination of the probation, he or she must apply for those clinical privileges that were subject to the probation. Application of clinical privileges will require completion of a medical staff application in addition to a new clinical privilege list. No application fees will be imposed with this application.

9.A.2 Failure to satisfy threshold eligibility criteria:

Failure of an individual to satisfy any of the threshold eligibility criteria set forth in this Policy results in immediate automatic relinquishment of appointment and clinical privileges as of the date of the Medical Staff Support Office learns of such failure.

9.A.3 Failure to provide requested information:

If a practitioner fails to provide information pertaining to the practitioner's qualifications for appointment, reappointment or clinical privileges in response to a written request from the Credentials Committee, the MEC, the Administrator, the chief medical officer, or any other committee authorized to request such information, all clinical privileges of the practitioner shall be immediately and automatically relinquished until the information is provided to the satisfaction of the requesting party. The automatic relinquishment shall be effective as of the date the requesting party determines that the information has not been provided. Related Medical Staff Policies include MS 900-003 Burden of Proof, MS 960-100 Practitioner Wellness, 980-050 Code of Conduct and MS 980-150 Reporting Disciplinary Actions.

9.A.4 Failure to provide information that could affect privileges at PAMC:

If a practitioner fails to advise the Medical Staff Services office of any action or event that could affect the practitioner's qualifications for clinical privileges within 30 days of any such action being taken or such event occurring, the practitioner's clinical privileges shall be immediately and automatically relinquished, effective the date that the Medical Staff Services learns of the action or event. Examples of such actions include but are not limited to: Loss or suspension of privileges at another healthcare facility, arrest for a DUI/DWI, conviction thereof, arrest or conviction of a crime against a person, or an action taken by a licensing board, disciplinary action by the human resources department of Providence or termination of employment contract with Providence if applicable, etc. Related Medical Staff Policies include MS 900-003 Burden of Proof, MS 960-100 Practitioner Wellness, 980-050 Code of Conduct and MS 980-150 Reporting Disciplinary Actions.

9.A.5 Drug Enforcement Administration (DEA) Certificate:

If a practitioner's right to prescribe controlled substances is revoked, restricted, suspended or placed on probation by a proper licensing authority, his or her privileges to prescribe such substances in the Medical Center will also be revoked, restricted, suspended or placed on probation automatically. Upon reinstatement of the practitioner's DEA certificate, he or she must complete a new application for the privilege to prescribe controlled substances in the Medical Center.

9.A.6 Medical Records Timely Completion:

The failure to prepare and/or to complete medical records in a legible and timely fashion, as defined in Providence Alaska Medical Center Policies, may result in limitation or automatic relinquishment of some or all of the practitioner's rights and clinical privileges. The practitioner will be given written notice and sufficient time to complete the medical records as set forth in the Delinquent Medical Record Completion and Suspension Policy. Automatic relinquishment imposed for non-completion of medical records is not a result of a quality of care concerns and therefore, providers who are on call for the Emergency Department or for Community Call are expected to fulfill their emergency call responsibilities and are expected to perform emergent/urgent cases resulting from their on-call duties. Elective cases however will not be scheduled until compliance with medical records requirements can be verified.

9.A.7 Professional Liability Insurance:

A practitioner's appointment and clinical privileges are immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Medical Staff. The practitioner may be reinstated when proof of coverage is provided to the Medical Staff Office with a satisfactory written explanation of the practitioner's failure to maintain the minimum amount of professional liability insurance as required.

9.A.8 Office of Inspector General List of Excluded Providers:

If a practitioner is so listed on the Office of the Inspector General's List of Excluded Individuals/Entities, such practitioner's medical staff membership and privileges shall be automatically suspended. The practitioner will be eligible to reapply for membership and privileges upon the practitioner's reinstatement with the applicable Federal health care program. A Physician who has opted out of Medicare and/or Medicaid is qualified for medical staff membership for the purposes of this section.

9.A.9 Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony or misdemeanor involving the following will result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse.

9.A.10 Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Medical Center Administration, after appropriate notice has been given, may, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

9.A.11 Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, will result in the automatic relinquishment of clinical privileges.

9.A.12 Failure to Comply with Request for Fitness for Practice Evaluation:

- (a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

- (b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

9.A.13 Failure to Respond to Collegial Intervention:

The Medical Executive Committee may determine that an individual's clinical privileges be relinquished for a stated period of time of less than 30 days (or several periods of time, progressively, as the Medical Executive Committee deems fair under the circumstance) if it finds that the individual has failed to meet expectations established through collegial intervention or other progressive steps. If the Medical Executive Committee determines to do so, it shall provide the individual an opportunity to meet with one or more designated Leaders and specify the conditions for reinstatement.

9.A.14 Reinstatement from Automatic Relinquishment and Automatic Resignation:

- (a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.
- (b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff or Allied Health Staff.
- (c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (d) below.
- (d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chair, the chair of the Credentials Committee, the Chief of Staff and the Chief Medical Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Medical Center. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.
- (e) Failure to resolve a matter leading to an automatic relinquishment within 90 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Allied Health Staff.

ARTICLE 10: FAIR HEARING PLAN

10.A. INITIATION OF HEARING

10.A.1 Triggering Events:

- (a) Grounds for Hearing: Except as otherwise provided in the Bylaws, the following adverse recommendations or actions with respect to an individual practitioner on staff or applicant shall be grounds for a hearing upon timely and proper request by the practitioner or applicant:
 - (i) Denial of medical staff/AHP membership (excluding those instances in which the applicant does not meet threshold eligibility requirements).
 - (ii) Denial of medical staff reappointment (excluding those instances, i.e. conditional reappointment, in which the practitioner does not meet threshold eligibility requirements).
 - (iii) Suspension of medical staff/AHP membership or clinical privileges for greater than 14 days. (Does not apply to applicants)
 - (iv) Revocation of medical staff/AHP membership. (Does not apply to applicants)
 - (v) Denial of requested clinical privileges (excluding those instances in which the practitioner or applicant does not meet threshold eligibility requirements).
 - (vi) Involuntary reduction of current clinical privileges. (Does not apply to applicants)
 - (vii) Termination of all clinical privileges. (Does not apply to applicants)
 - (viii) Mandatory concurring consultation requirement (i.e. the consultant must approve the course of treatment in advance)
 - (ix) Any other action reportable to the State of Alaska or to the National Practitioner Data Bank if the action were to become final.
- (b) The Board may authorize or request the MEC to conduct a hearing for circumstances in which no prior grounds for a hearing existed.
- (c) All other circumstances will not warrant a hearing and appeals. Receiving written documentation from the practitioner or an informal meeting with the MEC, however, will be considered by the Chief of Staff, the Chief Medical Officer, and Department Chair.

10.A.2 Notice of Adverse recommendation or Action:

The Administrator promptly gives the practitioner or applicant special notice of an adverse recommendation or action taken pursuant to Article 10, Section 10.A.1(a)-(i). The notice shall:

- (a) Advise the practitioner or applicant of the recommendation or action, the reasons therefore, and his or her right to request a hearing pursuant to the provisions of the Bylaws and this Fair Hearing Plan;
- (b) Summarize the rights of the practitioner or applicant in the hearing;
- (c) Specify that the practitioner or applicant has thirty (30) days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Article 10, Section 10.A.3;
- (d) 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;

- (e) 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;
- (f) State that upon receipt of the practitioner's or applicant's hearing request, the Administrator will notify the practitioner or applicant of the date, time and place of the hearing; and
- (g) State that if the practitioner or applicant wishes representation by an attorney, he or she must so notify the Administrator within ten (10) days of requesting a hearing.

10.A.3 Request for Hearing:

The practitioner or applicant shall have thirty (30) calendar days after receiving a notice under Article 10, Section 10.A.2 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.

10.A.4 Failure to Request a Hearing:

A practitioner or applicant who fails to request a hearing within the time and in the manner specified in Article 10, Section 10.A.3 will lose his or her right to any hearing or appellate review to which he or she might otherwise have been entitled. The Administrator shall promptly send the practitioner or applicant special notice of each action taken under any of the two following sub-sections and shall notify the Chief of Staff of each action.

- (a) After adverse recommendation (as defined above in Article 10, Section 10.A.1(a)(i)-(a)(ix) by the MEC: The Board shall consider the adverse recommendation within thirty (30) days of receipt of the recommendation.
 - (i) If the Board agrees with MEC's recommendation. If the action of the Board accords in all respects with the MEC's recommendation, it shall then become effective as the final decision of the Board.
 - (ii) If the Board does not agree with MEC's recommendation. If, on the basis of the same information and material considered by the MEC in formulating its recommendation, the Board 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 Board shall then take final action on the reconsidered recommendation. The Administrator shall send the practitioner or applicant special notice of any such referral back, the subsequent recommendation of the MEC, and the action taken by the Board thereon.
- (b) After Favorable Recommendation By the MEC Followed By Adverse (as defined above in Article 10, Section 10.A.1(a)-(i) Decision By the Board: If the Board proposes to take an action adverse to the practitioner or applicant 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 Article 10, Section 10.A.4(ii)

10.B. 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 Director of Medical Staff Services who will in turn notify the Chief of Staff. The Director of Medical Staff Services shall arrange and schedule a hearing, and the Chief of Staff shall send the practitioner or applicant a special notice of the time, place and date of the hearing within fifteen (15) business days of receipt of request. The hearing date shall not be less than thirty (30) business days nor more than sixty (60) business days after receipt of the special notice, unless the practitioner or applicant 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 thirty (30) business days after the request for an expedited hearing.
- (b) Statement of Issues, Events, and Witnesses: Following the notice of hearing time, place and date, an additional notice of hearing will be hand delivered or mailed within ten (10) business days that must contain a concise statement of the practitioner's or applicant's alleged acts or omissions, a list by number of any 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 practitioner or applicant requesting the hearing, and that the practitioner or applicant and the practitioner's or applicant's counsel have sufficient time to study this additional information and rebut it.
- (c) Witness List: The practitioner or applicant 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 or applicant's behalf within ten (10) business 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 Panel:
 - (i) Appointment: A hearing occasioned by an adverse recommendation by the MEC or an adverse action by the Board, is conducted by a Hearing Panel appointed by the Administrator and/or the Chief of Staff or his or her designee and composed of three health professionals. None of the members of the Hearing Committee may be in direct economic competition with the practitioner or applicant. The Chief of Staff or his or her designee shall designate one of the appointees as Chair of the Hearing Panel.
 - (ii) Service on Hearing Committee: A Member is not disqualified from serving on a Hearing Panel merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be. The practitioner or practitioners whose adverse recommendation or action initiated the hearing shall not serve on the Hearing Panel. The members of the Hearing Panel must give fair and impartial consideration of the case.

(e) Provision of Relevant Information:

- (i) Prior to receiving any confidential documents, the individual requesting the hearing shall agree that all documents and information shall be maintained as confidential, and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (ii) No information shall be provided regarding other individual practitioners on the Medical Staff, though the MEC may use data compilations reflecting in the aggregate the practice patterns of other practitioners in the department or specialty which do not disclose the names of individual practitioners.
- (iii) Prior to the hearing, a pre-hearing conference shall be held at which the Hearing Officer shall, in consultation with the MEC representative and the practitioner, set appropriate deadlines for pre-hearing matters, and establish other appropriate hearing procedures.
- (iv) Neither the individual nor any other person acting on behalf of the individual may contact Medical Center employees whose name appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing until the Medical Center has been notified of the request to contact such witnesses and has contacted the employees about their willingness to be interviewed. The Medical Center will advise the individual once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

10.C. HEARING PROCEDURE

- (a) Personal Presence: The personal presence of the practitioner or applicant is required at the hearing. A/An practitioner or applicant who fails without good cause to appear and respond to questions at the hearing shall lose his or her right to a hearing.
- (b) Hearing Officer: A hearing officer shall be appointed under Article Section 10.G. The hearing officer shall be an attorney at law who shall determine procedural questions and assist the hearing panel. The hearing officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. He or she shall determine the order of procedure during the hearing and shall make all rulings on matters of procedure and evidence.
- (c) Representation: The practitioner or applicant may be accompanied and represented at the hearing by an attorney or other person of the practitioner's or applicant's choice as long as proper notice was given as identified in Article 10, Section 10.A.2(g). The MEC and the Board, if its recommendation or action prompted the hearing, shall appoint an individual to represent it. Article 10, Section 10.G(c) of this Fair Hearing Plan, governs representation of either party by an attorney at law.
- (d) Rights of Parties: During a hearing, each party may:
 - (i) Call and examine witnesses;
 - (ii) Introduce exhibits;
 - (iii) Cross-examine any witness on any matter relevant to the issues; and
 - (iv) Submit a written statement at the close of the hearing.

A record of the hearing shall be made by a court reporter or an electronic recording unit.

If the practitioner or applicant does not testify on his or her own behalf, he or 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 panel is also entitled to consider all other relevant information that can be considered under the Bylaws in connection with credentialing 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 Panel 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 where the hearing is held. 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 practitioner or applicant who requested the hearing to come forward with evidence in response. After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the MEC or the Board unless it finds that the practitioner or applicant who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.
- (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 Panel may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of 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 Panel and the parties, if any, during the hearing process.
- (i) Postponement: Requests for postponement of a hearing may be granted by the Hearing Panel only upon showing of good cause and only if the request is made as soon as is reasonably practical or upon mutual agreement of the practitioner requesting the hearing and the Administrator, MEC and/or the Board.
- (j) Presence of Hearing Panel Members and Vote: The entire Hearing Panel must be present throughout the hearing and deliberations.
- (k) Recesses and Adjournment: The Hearing Panel 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 Panel must reconvene in a timely manner and in any event the recess must not exceed ten (10) business days

except by written consent of the practitioner or applicant. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Hearing Panel 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 (10) business days after the hearing is closed.

10.D. HEARING COMMITTEE REPORT AND FURTHER ACTION

- (a) Hearing Panel Report: Within ten (10) business days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations, including a statement of the basis for its recommendations, after review of the evidence, and shall forward the report along with the record and other documentation to the Administrator. The Administrator shall promptly send a copy of the Hearing Panel report to the MEC and the practitioner or applicant by certified mail or documented hand delivery (as defined in Article 10, Section 10.C(h)).
- (b) Action on Hearing Panel Report: Within ten (10) business days after receiving the Hearing Panel 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 Panel report to the Administrator
- (c) Notice and Effect of Result:

Notice: The Administrator shall promptly send a copy of the MEC's post hearing recommendation to the practitioner or applicant by special notice, to the Chief of Staff, to the MEC and to the Board.

- (i) Effect of Favorable Recommendation by the MEC: If the MEC's result is favorable to the practitioner or applicant, the result shall be promptly forwarded, together with all supporting documentation, to the Board, which, may adopt or reject the recommendation, in whole or in part, or refer the matter back to the MEC for further consideration. MEC shall have 30 business days to consider the information from the Board. After receiving a subsequent recommendation and any new evidence, the Board, shall within 30 business days, 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. MEC will again have 30 days to consider the information from the Board.
- (ii) If the Board's action after receiving the reconsidered recommendation of the MEC remains an adverse recommendation (as defined in Section 10.A.1(a)), the Board shall inform the practitioner or applicant of his or her right to request an appellate review by the Board as provided in Section 10.E of this Fair Hearing Plan. The Board notice shall inform him or her of each action taken under this Section, including a statement of the basis for the Board's decision.
- (iii) Effect of an Adverse recommendation (as defined above in as defined in Section 10.A.1(a)) by the MEC: If the Board, adopts the adverse recommendation of the MEC, the Board shall inform the practitioner or applicant of his or her right to request an appellate review by the Board as provided in Section 10.E of this Fair Hearing Plan. If, however, the Board, renders a decision different from the recommendation of the MEC, the matter shall be referred back to the MEC for reconsideration. MEC will have 30 business days to consider the information from the Board. The Board will have 30 business days to consider the information received back from the MEC. If the action of the Board after receiving the reconsidered recommendation of the MEC is favorable to the practitioner or

applicant, it shall become the final decision in the matter. If the action of the Board is adverse to the practitioner or applicant, the Board shall include a statement to the practitioner or applicant of the basis for the Board's decision and shall inform him or her of his or her right to request an appellate review by the Board as provided in Section 10.E of this Fair Hearing Plan.

10.E. INITIATION AND PREREQUISITES FOR APPELLATE REVIEW

- (a) Request for Appellate Review: If the Board decision is adverse, the practitioner or applicant shall have ten (10) business days after receiving notice under Section 10.D(c) to file a written request for an appellate review. The permissible grounds for an appeal shall be limited to the following: (1) There was substantial failure by the Hearing Committee to comply with this Plan and/or the bylaws of the Medical Center or Medical Staff during the hearing, so as to deny at fair hearing; and/or (2) The recommendations of the Hearing Committee were made arbitrarily or capriciously and/or were not supported by credible evidence. The request must be delivered to the Administrator, acting on behalf of the Board in person or by certified or registered mail and may include a request for a copy of the Hearing Panel report and record of all material if not previously furnished to him or her that was considered.
- (b) Failure to Request Appellate Review: A practitioner or applicant who fails to request an appellate review within the time and in the manner specified loses any right to an appellate review.
- (c) Notice of Time and Place for Appellate Review: The Administrator shall deliver a timely and proper request to the Chair of the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review that shall be not less than thirty (30) business days nor more than sixty (60) business days after the Administrator received the request; provided, however, that appellate review for a practitioner or applicant 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 thirty (30) business days after the Administrator received the request. No less than thirty (30) business days prior to the appellate review, the Administrator, acting on behalf of the board shall send the practitioner or applicant 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 practitioner or applicant wishes to be represented by an attorney at any appellate review, he or she must so notify the Administrator within ten (10) business days of the request for an Appellate Review.
- (d) Appellate Review Committee: The Chair of the Board shall appoint an Appellate Review Committee. The Appellate Review Committee shall consist of five members, at least two of whom shall be members of the Privileged or Honorary Staff who are not in direct economic competition with the practitioner or applicant, two who shall be members of the Board, and one who shall be a representative of Service Area administration. No person appointed to the Appellate Review Committee shall be a person who has instigated or participated in earlier proceedings in the case. The committee among themselves can appoint a chair, if necessary.

10.F. 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 10.F(b), and any other material that may be presented and accepted under Section 10.F(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 Fair

Hearing 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 10.A(1), A(2), or 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: Each party shall have the right to present a written statement in support of its position of the appeal. The written statement shall contain whatever objections the party may have to the findings, actions, and procedural rulings, together with the reasons for the objections. This written statement may cover any matters raised at any step in the hearing process. The other party involved shall then have ten (10) business days to respond. The statements shall be submitted to the appellate review committee and the other parties through the Administrator, acting on behalf of the Board, at least three (3) business days prior to the scheduled date of the review, except if the appellate review committee waives the time limit.
- (c) Presiding Officer: The chair of the Appellate Review Committee is the presiding officer. He or she determines the order or procedure during the review, makes all required rulings with the advice of the committee, and maintains 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 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 review body and as the review body 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, acting on behalf of the Board, 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 (3) business 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 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 review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review shall be adjourned at the conclusion of those deliberations.
- (h) Action by Appellate Review Committee: The Appellate Review Committee shall issue its recommendation no later than thirty (30) business days after the submission of oral arguments or written statements, whichever is later. The Appellate Review Committee may recommend that the Board affirm, modify or reverse the adverse result or action, or in its discretion, may refer the matter back to the MEC for further review and recommendation to be returned to it within thirty (30) business days. Within ten (10) business days after receipt of such recommendation after referral back, the Appellate Review Committee shall take

action. The Appellate Review Committee shall 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 MEC and the practitioner or applicant.

- (i) Action by Board: Within ten (10) business days after receipt thereof, the Board shall act upon the recommendation of the Appellate Review Committee. It may confirm, modify, or reject the decision appealed from. 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 10.F(j) at the request of either the MEC or the Board. The Board shall act on the recommendation of the Joint Conference Committee decision within 30 business days. The action of the Board after receiving the Joint Conference Committee's recommendation shall be effective as the final decision on the matter. The Board shall inform the MEC and the practitioner or applicant of its decision.
- (j) Joint Conference Review: The Joint Conference Committee shall consist of five members. The Board shall appoint three members. The Chief of Staff shall appoint two members from the Medical Executive Committee. Within thirty (30) business days after receiving a matter referred to it under this Fair Hearing Plan, the Joint Conference Committee shall convene to consider the matter and shall submit its recommendations to the Board

10.G. GENERAL PROVISIONS

- (a) Hearing Officer Appointment. The Chief of Staff shall appoint an attorney licensed in the State of Alaska, who is experienced in conducting hearings to serve as the Hearing Officer.
- (b) Hearing Officer Duties: The Hearing Officer shall:
 - (i) Preside at the hearing and make all procedural decisions including admissibility of evidence.
 - (ii) Assist the hearing panel members in understanding their role in the fair hearing.
 - (iii) Assist the hearing panel with the drafting of its decision.
 - (iv) NOT vote.
 - (v) Have no professional conflicts of interest with respect to PAMC and/or the involved practitioner or applicant.
- (c) Attorneys:
 - (i) At the Fair Hearing: The practitioner or applicant may be represented by an attorney at the hearing, provided he or she notified the Administrator within ten (10) business days of requesting the hearing.
 - (ii) At the Appellate Review Committee: The practitioner or applicant may be represented by an attorney at an appellate review provided he or she so notified the Administrator within ten (10) business days of requesting the appellate review.
 - (iii) Responsibility for Attorneys: If a practitioner or applicant elects to be represented by an attorney, he or she will be solely responsible for payment of all his or her attorney fees no matter which party prevails at the hearing.
 - (iv) Representation: The practitioner that requested the hearing shall be entitled to be accompanied and represented at the hearing and/or appellate review by an attorney or another person of his/her choice. The practitioner may choose to represent themselves. However, the Medical Executive Committee or the Board will be represented by an attorney in all proceedings.

- (d) Number of Hearings and Review: Notwithstanding any other provision of the Bylaws or of this Fair Hearing Plan, no practitioner or applicant 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 11: ALLIED HEALTH PROFESSIONALS

11.A. CONDITIONS OF PRACTICE

11.A.1 Standards of Practice for Allied Health Professionals in the Inpatient Setting:

- (a) Allied Health Professionals (APCs, CNMs and Dependent Providers) shall function with a collaborative or supervising agreement in the inpatient Medical Center setting. As a condition of being granted permission to practice at the Medical Center, all AHPs specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of AHPs in the Medical Center, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.
- (b) The following standards of practice apply to the functioning of AHPs in the inpatient Medical Center setting:
 - (i) Admitting Privileges. AHPs, other than CNMs, are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician. Appropriately qualified nurse midwives are eligible to request admitting privileges.
 - (ii) Consultations. AHPs, other than CNMs, may not independently provide patient consultations in lieu of the provider's Supervising Physician. AHPs may gather data and order tests; however, the Supervising Physician must personally perform the requested consultation within 24 hours (or more timely in the case of any emergency consultation request). Notwithstanding the provisions of this section, the Medical Executive Committee may determine that in the best interests of patient care, in specific services, AHPs may provide consultations as part of a care team, subject to OPPE and Medical Executive Committee oversight.
 - (iii) Emergency On-Call Coverage. It will be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact an AHP prior to the Supervising Physician. AHPs may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. The Supervising Physician must personally respond to all calls, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising Physician may direct an AHP to see the patient, gather data, and order tests for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.
 - (iv) Calls Regarding Supervising Physician's Hospitalized Inpatients. It will be within the discretion of the Medical Center personnel requesting assistance to determine whether it is appropriate to contact an AHP prior to the Supervising Physician. However, the Supervising Physician must personally respond to all calls directed to him or her in a timely manner.

- (v) Inpatient Rounds. An AHP may assist the Supervising Physician in fulfilling his or her responsibility to round on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate, in accordance with applicable policies.

11.B. OVERSIGHT BY SUPERVISING PHYSICIAN:

- (a) AHPs may function in the Medical Center only so long as they have a Supervising Physician.
- (b) Any activities permitted to be performed at the Medical Center by an AHP will be performed only under the oversight of the Supervising Physician.
- (c) If the appointment or clinical privileges of a Supervising Physician expire or are resigned, revoked or terminated, or the AHP fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician, the clinical privileges or scope of practice of the AHP will be automatically relinquished, unless he or she has another Supervising Physician who has been approved as part of the credentialing process.
- (d) As a condition of clinical privileges or scope of practice, an AHP and the Supervising Physician must provide the Medical Center with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the Chief Medical Officer within three days of any such change.

11.B.2 Questions Regarding the Authority of an AHP

- (a) Should any member of the Medical Staff, or any employee of the Medical Center who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an AHP to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the AHP. Any act or instruction of the AHP will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges or scope of practice granted to the individual.
- (b) Any question regarding the conduct of an AHP will be reported to the Chief of Staff, the Chair of the Credentials Committee, the relevant department chair, the Chief Medical Officer, or the Chief Medical Officer for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician.

11.B.3 Responsibilities of Supervising Physicians:

- (a) Physicians who wish to utilize the services of an AHP in their clinical practice at the Medical Center must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the AHP performs services or engages in any kind of activity in the Medical Center.
- (b) Supervising Physicians who wish to utilize the services of AHP in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 8.A.1 above.
- (c) The number of AHPs acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies

adopted by the Medical Center. The Supervising Physician will make all appropriate filings with the State Medical Board regarding the supervision and responsibilities of the AHP, to the extent that such filings are required.

- (d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the AHP (other than those employed by the Medical Center or an affiliate) in amounts required by the Board. The insurance must cover any and all activities of the AHP in the Medical Center. The Supervising Physician will furnish evidence of such coverage to the Medical Center. The AHPs will act in the Medical Center only while such coverage is in effect.

ARTICLE 12: CONFLICTS OF INTEREST

- (a) When performing a function outlined in this Policy, the Bylaws, the Medical Staff Rules and Regulations, or other relevant policies, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.
- (b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief of Staff (or the Chief of Staff-Elect if the Chief of Staff is the person with the potential conflict) or the applicable department or committee chair. The Chief of Staff or the applicable department or committee chair will make a final determination as to whether the provisions in this Article should be triggered.
- (c) The fact that a department chair or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.
- (d) The fact that a department or committee member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

ARTICLE 13: MEDICAL CENTER EMPLOYEES

- (a) Except as provided below, the employment of an individual by the Medical Center or one of its affiliates will be governed by applicable employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that applicable employment policies or manuals, or the terms of any employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.
- (b) A request for appointment, reappointment or clinical privileges, submitted by an applicant or member who is employed by the Medical Center or one of its affiliates, will be processed in accordance with the

terms of this Policy. A report regarding each practitioner's qualifications will be made to appropriate management personnel to assist with employment decisions.

- (c) If a concern about an employed member's clinical competence, conduct or behavior arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to appropriate management personnel. However, nothing herein will require the individual's employer to follow this Policy.

ARTICLE 14: AMENDMENTS AND ADOPTION

- (a) The amendment process for this Policy is set forth in the Bylaws.
- (b) This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations of the Medical Staff or Medical Center policies pertaining to the subject matter thereof.

APPENDIX A

ALLIED HEALTH PROFESSIONALS

The Allied Health Professionals currently practicing at the Medical Center as Licensed Independent Practitioners are as follows:

Psychologists

The Certified Registered Nurse Anesthetist currently practicing at the Medical Center as Advanced Practice Clinicians as follows:

Certified Registered Nurse Anesthetist

The Certified Nurse Midwives currently practicing at the Medical Center as Advanced Practice Clinicians are as follows:

Certified Nurse Midwife

The Allied Health Professionals currently practicing at the Medical Center as Advanced Practice Clinicians are as follows:

Advanced Practice Nurses

Physician Assistants

RN First Assistants

The Allied Health Professionals currently practicing at the Medical Center as Dependent Providers are as follows:

Perfusionists

Pathology Assistants

Surgical Assistants

Dental Assistants

APPENDIX B

The following are boards that have been approved for certification of members of the Allied Health Staff:

American Nurses Credentialing Center

American Association of Nurse Practitioners

American Association of Nurse Anesthetists Council on Accreditation of Nurse

Anesthesia National Commission on Certification of Physician Assistants

American Collage of Nurse Midwives

