

# **POLICIES AND PROCEDURES**

## **PROFESSIONAL STAFF**

### **PROVIDENCE HEALTH & SERVICES – OREGON**

*Providence Hood River Memorial Hospital*

*Providence Medford Medical Center*

*Providence Milwaukie Hospital*

*Providence Newberg Medical Center*

*Providence Portland Medical Center*

*Providence Seaside Hospital*

*Providence St. Vincent Medical Center*

*Providence Willamette Falls Medical Center*

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# **POLICIES AND PROCEDURES**

## **OF THE**

### **PROFESSIONAL STAFF**

#### **PROVIDENCE HEALTH & SERVICES – OREGON**

##### **Article I. DEFINITIONS**

1. “Chief Executive” means the individual(s) appointed by the Board to act on its behalf in the overall management of the Hospitals.
2. “Chief Executive and President” means the individual(s) acting as a subcommittee of the Board concerning issues of appointment and clinical privileges
3. “Board” means the board of directors responsible for conducting the affairs of Providence Health & Services – Oregon, which for purposes of these policies and procedures and except as the context otherwise requires shall be deemed to act through the authorized actions of the Oregon Community Ministry Board, the officers of the corporation and through the Operations Chief Executives of Providence Hood River Memorial Hospital, Providence Medford Medical Center, Providence Milwaukie Hospital, Providence Newberg Medical Center, Providence Portland Medical Center, Providence Seaside Hospital, Providence St. Vincent Medical Center and Providence Willamette Falls Medical Center
4. “Department” means a department of the Professional Staff as established by the joint action of the Medical Executive Committee and the Oregon Medical Executive Committee.
5. “Department Chair” means the Department Chair at the Primary Site, appointed by the MEC.
6. “Hospital” or “Hospitals” means Providence Hood River Memorial Hospital, Providence Medford Medical Center, Providence Milwaukie Hospital, Providence Newberg Medical Center, Providence Portland Medical Center, Providence Seaside Hospital, Providence St. Vincent Medical Center and/or Providence Willamette Falls Medical Center.
7. “Medical Executive Committee” or “MEC” means the Medical Executive Committee of each Hospital.
8. “Member” means a Member of the Professional Staff appointed to and maintaining membership in a category of the Professional Staff, in accordance with these policies and procedures. Each Member shall designate a Hospital(s) as his/her primary Hospital(s) (“Primary Hospital”) for purposes of voting, emergency call and department assignments, among other things.
9. “Policies” mean the Policies and Procedures of the Professional Staff. The Oregon Medical Executive Committee shall establish model PHSOR Policies to assist the MEC in developing appropriate Hospital specific Policies. The Oregon Medical Executive Committee shall determine which provisions are to remain uniform and which provisions are to serve merely as a guide.

10. “PHSOR” or “Oregon Region” means the Providence Health & Services – Oregon, which is comprised of Providence Hood River Memorial Hospital, Providence Medford Medical Center, Providence Milwaukie Hospital, Providence Newberg Medical Center, Providence Portland Medical Center, Providence Seaside Hospital, Providence St. Vincent Medical Center and Providence Willamette Falls Medical Center.

11. “The Professional Staff of Providence Health & Services - Oregon, PHSOR” or “Professional Staff” means the physicians (MD, DO), licensed oral and maxillofacial surgeons, dentists, podiatrists, nurse midwives, nurse practitioners, certified registered nurse anesthetists, and clinical psychologists who are granted membership at Providence Hood River Memorial Hospital, Providence Medford Medical Center, Providence Milwaukie Hospital, Providence Newberg Medical Center, Providence Portland Medical Center, Providence Seaside Hospital, Providence St. Vincent Medical Center and/or Providence Willamette Falls Medical Center..

12. “Oregon Medical Executive Committee” or “OMEC” means the Oregon Medical Executive Committee of the Professional Staff.

13. “Oregon Credentials Committee” or “OCC” means the PHSOR committee accountable for credentialing and privileging as defined in the Bylaws and these Policies.

14. “Days” means calendar days.

15. “Practitioner” means a licensed healthcare provider.

16. “Applicant” means a Practitioner who makes an application for Professional Staff membership.

17. “President” or “President Elect” means the President, or President Elect of each hospital’s Professional Staff.

## **Article II. MEMBERS OF THE PROFESSIONAL STAFF**

Members of the Professional Staff are certified registered nurse anesthetists, clinical psychologists, dentists, nurse midwives, nurse practitioners, oral and maxillofacial surgeons, physicians and podiatrists.

### **Section 1. Clinical Psychologist**

Clinical psychologist means a Practitioner licensed under ORS Chapter 675.

### **Section 2. Dentist**

Dentist means a Practitioner licensed under ORS Chapter 679.

### **Section 3. Nurse Midwife**

Nurse midwife means a Practitioner licensed under ORS Chapter 678 who is certified by the Oregon State Board of Nursing as qualified to practice in an expanded role as midwife within the practice of nursing

#### **Section 4. Nurse Practitioner**

Nurse practitioner means a Practitioner licensed under ORS Chapter 678 who is certified by the Oregon State Board of Nursing as qualified to practice in an expanded specialty role within the practice of nursing.

#### **Section 5. Oral/Maxillofacial Surgeon**

Oral/maxillofacial surgeon means a licensed dentist under ORS Chapter 679 with advanced training qualifying the dentist for board certification by the American Board of oral/maxillofacial Surgery.

#### **Section 6. Physician**

Physician means a practitioner with a M.D. or D.O. degree licensed under ORS Chapter 677.

#### **Section 7. Podiatrist**

Podiatrist means a practitioner licensed under ORS Chapter 677.

#### **Section 8. Certified Registered Nurse Anesthetist**

Certified Registered Nurse Anesthetist means a practitioner licensed under ORS Chapter 678 who is certified by the Oregon State Board of Nursing as qualified to practice in as a nurse anesthetist within the practice of nursing.

### **Article III. CATEGORIES OF THE PROFESSIONAL STAFF**

The categories of the Professional Staff are Active, Active Provisional, Courtesy, Affiliate, Inactive and Honorary. The primary Hospital shall be the Hospital where the Member centers the principal portion of their clinical activities. An Active Member may designate more than one Hospital for purposes of voting, emergency call and department assignments. Request for category changes will be accepted no more than once in a rolling twelve-month period, except by written petition to and recommendation of the OCC.

#### **Section 1. Active**

A. Qualifications. The Active category shall consist of those Members who (a) have served as Active Provisional Members for the period of time necessary to demonstrate that they meet the eligibility requirements for advancement to Active status, and (b) choose to seek such advancement. Active Members must meet the general qualifications set forth in Article IV, Section 1 of these Policies.

- B. Responsibilities. Active Members shall assume all the functions and responsibilities of membership in the Active category including the following: (1) caring for unassigned patients, emergency service care, consultation and teaching assignments as determined by the Department and approved by the MEC; (2) serving on Professional Staff committees, as assigned; (3) serving as Chair of Professional Staff Departments or Committees, as assigned; (4) participating in quality assessment and monitoring activities, including evaluating Active Provisional Members, as assigned by Department or Committee Chairs; and (5) conducting a principal part (at least 40%) of his/her hospital practice within the PHSOR. In addition, Active Members are expected to attend Professional Staff, Department and/or Committee meetings.

Members of the Active category shall be entitled to vote in Committee and Department meetings, General Staff meetings and shall be eligible to hold office. Preference for elective admissions will be given to Active Members.

- C. Criteria for Achieving and Maintaining Active Category Status: To achieve and maintain Active category status, each Member must demonstrate compliance with all of the following:

- 1) Minimum of 36 units of patient and Professional Staff service per calendar year;
- 2) Community standards of clinical and service quality (includes adverse reports or quality concerns); and
- 3) Evidence of continuing medical education.

Patient and Professional Staff service units can be earned for the following activities:

- 1) Inpatient or outpatient PHSOR admission as admitting, attending, referring or primary care practitioner (one unit per admission);
- 2) Inpatient or outpatient surgical, diagnostic or therapeutic procedure performed in PHSOR as the Member performing the procedure, assisting in the procedure or referring the patient for the procedure (one unit per procedure);
- 3) PHSOR inpatient consultation noted in the patient medical record (one unit per consultation); and
- 4) Participation in PHSOR emergency call (one unit per call period with a maximum of 5 units per year).

Departments may identify additional mechanisms for earning units of service, such as attendance at Department or Committee meetings, with the approval of the MEC and OMEC.

Members who cannot demonstrate the minimum activity level due to limited hospital practice may request an exception by submitting a written declaration to the OCC stating that a principle part (at least 40%) of his/her hospital practice occurs within PHSOR.

If, at the time of reappointment, the Member cannot meet the minimum activity level, the Member will be offered the opportunity to withdraw his/her application or apply for Courtesy or Affiliate Status.

A Member may not be eligible for Active status until he/she can demonstrate 36 units of patient and Professional Staff service during a 12-month period.

## **Section 2. Active Provisional**

- A. Qualifications. Active Provisional Members must meet the general qualifications set forth in Article IV, Section 1 (General Qualifications) of these Policies. The Active Provisional category shall consist of Members being considered for the Active category. Eligibility for the Active category will be based on the Member meeting the required 36 units of patient and Professional Staff service and all other requirements of the Active category. The evaluation and recommendation of the Department Chair is required. If after 24 months in the Active Provisional category the Member cannot meet the minimum activity level for Active status the Member will be offered the opportunity to withdraw his/her application or apply for Courtesy or Affiliate Status
- B. Responsibilities. Members of the Active Provisional category shall assume the following functions and responsibilities including: (1) caring for unassigned patients, emergency service care, consultation and teaching assignments as determined by the Department and approved by the MEC; (2) serving on Professional Staff committees, as assigned, but not in the capacity of Chair; (3) participating in quality assessment and monitoring activities, as assigned by Department or Committee Chairs; and (4) conducting a principal part (at least 40%) of his/her hospital practice within PHSOR. In addition, Members of the Active Provisional category are expected to attend Professional Staff, Department and/or Committee meetings. Members of the Active Provisional category shall be entitled to vote in Committee and Department meetings, but not at the General Staff meeting, and shall be ineligible to hold office.

## **Section 3. Courtesy**

- A. Qualifications. Courtesy Members must meet the general qualifications set forth in Article IV, Section 1 (General Qualifications) of these Policies. A Member of the Courtesy category may submit an application for the Active category at any time after the Member determines that he/she meets the eligibility requirements. The evaluation and recommendation of the Department Chair is required.
- B. Responsibilities. Courtesy Members may be required to assume responsibility for the following: (1) care for unassigned patients, emergency service care, consultation and teaching assignments as determined by the Department and approved by the MEC; and (2) other responsibilities as assigned by the Department Chair. Members of the Courtesy category shall have no required Committee responsibilities, may not vote or hold office. Members of the Courtesy category are encouraged to attend Professional Staff, Department and Committee meetings.

## **Section 4. Affiliate**

Affiliate Members must meet the general qualifications set forth in Article IV, Section 1, (General Qualifications) of these Policies. Affiliate Members shall include Members who do not admit to the Hospital, or who do not have a hospital practice i.e., no clinical privileges, but who wish to be associated with the Professional Staff for purposes of continuing education,

collegial association and/or to establish and maintain a referral network. Affiliate category Members shall be entitled to attend meetings, may serve on committees as assigned, but may not vote or hold office.

#### **Section 5. Inactive Status**

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

#### **Section 6. Honorary**

The Honorary category shall consist of Members who have retired from hospital practice but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the hospital, and their previous long standing and exemplary service, and who continue to exemplify high standards of professional and ethical conduct. Members appointed to the Honorary category shall not be eligible to admit or treat patients at the Hospitals, to vote, to hold office or to serve on standing Professional Staff committees, but may be appointed to special committees. They may attend Professional Staff meetings, and will be eligible for limited Providence benefits, as applicable. The Honorary status is exempt from paying annual Professional Staff dues, and will not be reappointed.

#### **Section 7. Alumni**

The Alumni category shall consist of Members who are in good standing that have retired from practice. Members appointed to the Alumni category shall not be eligible to admit or treat patients at the Hospitals, to vote, to hold office, or to serve on standing Professional Staff committees, but may be appointed to special committees. They may attend Professional Staff meetings, and will be eligible for limited Providence benefits, as applicable. The Alumni category is exempt from paying annual Professional Staff dues, and will not be reappointed.

### **Article IV. MEMBERSHIP**

#### **Section 1. General Qualifications and Acknowledgements**

Every applicant who seeks, or is granted, Professional Staff membership must continuously demonstrate to the satisfaction of the Professional Staff and the Board the following qualifications, which are based on the Providence Health & Services Core Values (Respect, Compassion, Justice, Excellence and Stewardship) and the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies.

- A. Patient Care: The member will provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

1. The member will demonstrate the knowledge, skills, behaviors and attitudes to provide quality patient services and perform the clinical privileges granted.
  2. Practices, policies and processes shall be consistent with local practice guidelines or published standards from nationally recognized organizations and supportive of The Joint Commission and governmental organizations, such as Centers for Medicare and Medicaid Services (CMS), regulations.
  3. The member will respond to a request for inpatient consultation within a reasonable time frame (via telephone or web), and will see the patient in person, when specifically requested within the time frame determined by the member who is requesting the in person consult.
- B. Medical Knowledge: The member will demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of this knowledge to patient care and the education of others.
- C. The member will provide patient care services within the limits of his/her valid, current license issued by the State of Oregon and within his/her professional skills and abilities.
1. A physician member/applicant DO or MD must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or an accredited Canadian residency program. The physician member/applicant must be board certified, or become board certified within 5 years of completion of training in his/her specialty, as defined by the appropriate specialty board of the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC). Only ABMS, AOA, RCPSC, or CFPC are recognized for meeting board certification requirements for a physician member/applicant. Credentials will be reviewed on a case by case basis for specialties not represented by ABMS, AOA, RCPC, or RCPSC board certification.

Oral/Maxillofacial Surgeons must be board certified by the American Board of Oral Maxillofacial Surgery (ABOMS).

Podiatrists must be board certified by the American Board of Foot and Ankle Surgery (ABFAS) within seven years of the completion of his/her post-graduate medical training.

Nurse Practitioners, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists must be certified as defined by privilege criteria.

Board certification must be maintained by all members as noted above and will be required at the time of initial appointment and reappointment. If the member's specialty board requires periodic recertification or maintenance of certification, then the member is required to take all necessary steps in a timely fashion to

remain board certified and in good standing with his/her specialty board in order to retain professional staff membership. This applies to all new applicants as of the effective date of these policies. This does not apply to existing members of the medical staff of a facility who became members prior to the date designated by resolution of their respective hospital MEC.

If a member fails to attain and/or maintain board certification as specified above, the member shall be deemed an automatic voluntary resignation of membership/privileges for no longer meeting the membership qualifications. The applicant may apply for membership/privileges after obtaining board certification. Hearing and appellate review rights do not apply to automatic voluntary resignations for not meeting the board certification membership qualifications.

- D. The member shall be free from any physical, psychological or behavioral impairment that would, with reasonable accommodation, prevent the member from performing the essential functions of the member's practice and the clinical privileges requested.
- E. The member's practice shall be evaluated on the basis of the principles of evidence-based medicine, which is defined as integrating individual clinical expertise with the best available external clinical evidence from systematic research informed by local outcomes data.
- F. Practice-Based Learning and Improvement: The member shall demonstrate the ability to use scientific evidence and methods to investigate, evaluate, and improve their patient care practices. The members shall endorse constant self-evaluation and life-long learning to identify strengths, deficiencies, and limits to their own knowledge and expertise. Based on these efforts, members will set learning and improvement goals, identify and perform appropriate learning activities, adopt methods to analyze their practice, use quality improvement methods and implement improvement changes. They will incorporate formative evaluation feedback into their daily practice and assimilate evidence from scientific studies related to their patients' health problems. Members will use information technology to optimize learning and participate in the education of patients, families, students, residents, and other health professionals.
- G. Interpersonal and Communication Skills: The member shall demonstrate interpersonal and communication skills that enable him/her to establish and maintain professional relationships with patients, families, visitors, members of the community and other members of the health care team including hospital management and employees. The member shall be in compliance with the Attending-Consulting Communication Protocol referenced in Exhibit A as applicable and ensure effective communication when handing over patient care to other healthcare team members.
- H. Professionalism: Members demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society. The Member shall:
  - 1. Understand that all Providence hospitals are Catholic institutions and Members agree to conform to the Providence Health & Services Mission and Core Values and the

Roman Catholic moral tradition as articulated in such documents as The Ethical and Religious Directives for Catholic Health Care Services (ERDs).

2. Provide appropriate care regardless of patients' age, race, culture, gender, religion, ethnic background, sexual orientation, language, socioeconomic status, mental capacity, physical disability or disease status.
  3. Complete the Caring Reliably training and utilize the tools, tones, and safety behaviors.
  4. Avoid providing medical care whenever possible to himself/herself or immediate family members, e.g., spouse, parents, children.
  5. Maintain the confidentiality of protected health information (including demographic information that can be used to identify the patient) and any other patient, physician, medical, or financial information, whether paper, oral, or electronic. Protected health information shall not be released to any individual, organization or agency without proper authorization. Inappropriate or indiscriminate release of protected health information is a serious breach of privacy with possible legal and criminal sanctions. All information regarding patients, physicians and/or their practices is confidential. No member shall have access to, or the right to review paper or electronic patient records or to disclose this information except as needed to provide treatment, payment activities or for administrative purposes.
- I. Systems-Based Practice: The member shall demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

The member shall:

1. Adhere to all professional staff obligations appropriate to the member's category;
2. At all times maintain eligibility and qualify for participation in the Medicare and Medicaid programs. (Nurse Midwives are ineligible to participate in the Medicare Program, therefore, the only provision that applies to the nurse midwives is the Medicaid provision.)
3. Comply with Providence Health & Services, Oregon Region Policies that pertain to the Professional Staff, some of which are listed as Exhibit A to these Policies. Copies of Hospital policies shall be available in the Medical Staff Office upon request. Excerpts from the Policies and the Providence Health & Services, Oregon Region Policies are included in the Professional Staff Expectations document, which is signed at appointment and reappointment.
4. When choosing between alternative treatment options realize that the burden of proof of value (safety, efficacy, cost) should be on those who advocate the newer or more expensive or more invasive option.
5. Support the concept of standardization of practice based upon our understanding that standardizing practice helps us document our processes, measure our outcomes and

aids in optimizing effective team process thus supporting quality outcomes and a culture of safety.

6. Be aware that their practices will be evaluated based upon how well they support a culture of patient safety as defined by evidence, patient safety experts, patient safety organizations and other high reliability organizations.

G. Non-Physician Members: All Members who are not physicians shall, depending on licensure and clinical privileges, provide patient care services within limits of licensure with appropriate levels of supervision and/or in coordination with physician Members as defined in Section G, 1 Specialties and/or in privilege criteria. Non-physician Members must have the ability to meet Medicare/Medicaid conditions of participation and The Joint Commission standards, and conditions of reimbursement to the Hospital for services.

1. Specialties

- a) Clinical Psychologists: A clinical psychologist with clinical privileges may participate in patient care and perform psychological testing, evaluation, counseling or other activities within the scope of his/her clinical privileges. Clinical psychologists may not admit patients or write orders. A physician Member must admit the patient and be responsible for the care of the patient during hospitalization.
- b) Dentists and Oral/Maxillofacial Surgeons: The patient of a dentist with clinical privileges may, with the concurrence of an appropriate physician Member, be admitted to the Hospital. The concurring physician Member shall assume responsibility for the overall aspects of the patient's care throughout the Hospital stay, including the medical history and physical examination. Dentists are responsible for the part of the patient's history and physical examination that relates to the practice of dentistry. Dentists and Oral/Maxillofacial Surgeons may be granted clinical privileges to perform admission history and physical examinations if they document compliance with the appropriate training requirements recommended to and approved by the Board.
- c) Oral and Maxillofacial Surgeons with admitting privileges may admit patients to the hospital, but are expected to obtain appropriate consultation when the patient's condition is outside his/her area of expertise or requires treatment outside his/her licensure or delineated clinical privileges. Oral/maxillofacial surgeons may be granted clinical privileges to perform admission history and physical examinations if they document compliance with the appropriate training requirements recommended to and approved by the Board.
- d) Nurse Practitioners and Nurse Midwives: Nurse practitioners and nurse midwives with admitting privileges may admit patients to the Hospital, but are expected to obtain appropriate consultation when the patient's condition is outside his/her area of expertise or requires treatment outside his/her licensure or delineated clinical privileges. Nurse practitioners and nurse midwives may be granted clinical privileges to perform admission history and physical examinations if they

document compliance with the appropriate training requirements recommended to and approved by the Board.

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

## **Section 2. Professional Staff Application Fees, Reappointment Fees and Dues**

- A. An application fee and annual Professional Staff dues, as recommended by each MEC and approved by the OMEC, will be required for all applicants and Members.
- B. Annual dues fees shall be paid by all Members with the exception of the Honorary Staff, at each Hospital where clinical privileges are held.
- C. In February of each year, Members shall be billed for annual dues. If no payment is received within 60 days, the Member will be notified by certified mail that payment must be received within 10 days or his/her voluntary resignation will be accepted.
- D. A portion of Professional Staff dues may be used for Early Assistance Program Services as defined in Article XI, Section 1; to provide limited Internet access through the PHSOR firewall, and electronic mail accounts on the PHSOR servers. Members shall comply with the requirements of Article XVII, Section 7 in the use of such Internet and electronic mail access.

## **Section 3. Professional Liability Insurance**

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

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

- A. Organized Health Care Arrangement. In order to facilitate the disclosure of protected health information between PHSOR services and programs under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), PHSOR has established an Organized Health Care Arrangement under 45 CFR 164.501 (“Providence OHCA”). All PHSOR facilities, services and programs, Providence employees, and practitioners and other clinicians who are members of the Professional Staff and/or who otherwise have Professional Staff privileges at Hospitals’ facilities, services or programs have been invited to participate in the Providence OHCA. The Professional Staff, through this Policy, has accepted the invitation to participate in the Providence OHCA. Under the Providence OHCA, all of the members, including members of the Professional Staff, may rely on a Joint Notice of Privacy Practice and Acknowledgment. Further, members of the Providence OHCA may use and disclose protected health information in the conduct of their joint operations and joint activities, all in a manner consistent with the requirements of HIPAA.
- B. Notice of Privacy Practices. Each Member shall be required to use and conform to the terms of the Joint Notice of Privacy Practice developed and used by PHSOR with respect to protected health information created or received as part of each Member’s participation in the Providence OHCA and to comply with all applicable Providence, Professional Staff and HIPAA requirements, policies and procedures relating to the confidentiality of protected health information.

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

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

## **Article V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT**

### **Section 1. Objectives**

- A. To assist in fulfilling the responsibility of the Professional Staff to assure that practitioners permitted to provide patient services independently in the Hospital are granted clinical privileges consistent with their individual training, experience, current competency and other qualifications;
- B. To assure that each eligible applicant is afforded equal opportunity to be appointed or reappointed to the Professional Staff;

- C. To assure that adequate information pertaining to education, training, relevant experience, and current competency is reviewed by the appropriate individuals and committees prior to rendering a recommendation to the Board or its designee.

## **Section 2. Conditions and Duration of Appointments**

Members must be available to respond by phone, and when clinically indicated in person, to the Hospital(s) within thirty (30) minutes when on the published emergency call schedule.

Initial appointments and all reappointments shall be for a period of no greater than two years. Upon application for reappointment on or after the age of seventy five (75), applicants will be reappointed on an annual basis. All Active, Active Provisional, Courtesy, Affiliate and Inactive Members must adhere to this requirement.

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

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

As a condition of appointment each applicant agrees to notify the Chief Executive promptly of the following: (1) any sanction, restriction, suspension, probation, termination or other change in licensure, (2) any change in professional liability insurance coverage, (3) any sanction, restriction, denial or surrender of the practitioner's hospital privileges or professional or medical staff membership in another hospital, (4) any professional liability settlement or judgment, (5) any felony criminal conviction, (6) any conviction of drug or alcohol offense, (7) any entry or participation in a rehabilitation program, (8) any change in health status that relates to the ability to perform the clinical privileges requested, (9) any revocation, suspension

or voluntary relinquishment of practitioner's license or DEA certificate, (10) any adverse determination by a medical professional review organization, or (11) the commencement of a formal investigation or the filing of charges by any federal or state agency against the practitioner, unless such information is exempt from disclosure by law. In the event a practitioner is in a rehabilitation or diversion program, applicant agrees to report to the Chief Executive upon entering the program, on a quarterly basis thereafter and on discontinuation of the program, either successfully or unsuccessfully. The practitioner shall authorize the Program to submit a written statement to the Chief Executive regarding the practitioner's treatment.

### **Section 3. Nondiscrimination**

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

### **Section 4. Application for Appointment**

Eligible applicants desiring appointment to the Professional Staff shall complete and submit a Board approved application. Currently, the application is processed through a Credentials Verification Organization (CVO). The CVO obtains all relevant documentation required in the application, including primary source verification where required. The application shall specify the category of Professional Staff appointment, clinical privileges requested and shall include primary source verifications as indicated by an asterisk (\*):

- A. Licenses and registrations, current and previous\*
- B. Board certifications\*
- C. National Practitioner Data Bank query report\*
- D. DEA certification, if applicable
- E. Documentation of current clinical competence\*
- F. Military history
- G. Medical, IHP and other graduate education and training\*
- H. Continuing medical education (CME), related, at least in part, to the privileges granted
- I. Professional society memberships
- J. Medical/clinical practice current and prior\*
- K. Hospital affiliations, current and prior\*
- L. Teaching appointments
- M. Liability insurance carriers, including current coverage limits\*
- N. Malpractice claims history\*
- O. History of adverse actions, including revocation, suspension, reduction, limitation, probation, non-renewal, voluntary or involuntary relinquishment, withdrawal or failure to proceed with an application, or other professional sanction for any of the following:
  - state medical license,
  - professional registration/license,
  - DEA/controlled substance registration,
  - academic appointment,
  - membership on any hospital medical staff or managed care organization,
  - clinical privileges at any other hospital,
  - prerogatives/rights on any medical staff,

- other institutional affiliation or status threat,
  - professional society membership or board certification,
  - participation in Medicare, Medicaid or other government programs,
  - focused review required by Peer Review Organizations or similar regulatory agency,
  - current investigations and current or pending denials.
- P. Health status as it relates to privileges requested, with or without accommodations,
- Q. Professional peer references.\*
- R. Criminal Background Checks at initial appointment, and as deemed necessary.\*
- S. Contact information including, but not limited to: current office addresses, phone, fax, and e-mail addresses.

Every application for Professional Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of his/her obligation to abide by the Bylaws, Policies and other policies and rules governing the Hospital, and to provide continuous care and supervision of his/her patients, including identification of Member(s), with comparable privileges, agreeing to provide call coverage.

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

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

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

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

## **Section 5. Appointment Process**

- A. **Primary Hospital(s)**. The applicant's Primary Hospital(s) is responsible for the application process.
- B. **Complete Application**. A complete application is required, which includes:
- 1) a complete, signed application form with complete verification of information, (refer to Section 4)
  - 2) a complete, signed request for privileges,
  - 3) the required application fee;
  - 4) other information as requested.

In the event any required information is not received, assistance may be requested from the applicant. Failure of an applicant to adequately respond to a request for assistance will, after thirty days, be deemed a voluntary withdrawal of the application. In the event any information provided by the applicant varies significantly from information obtained during the appointment process, the applicant will be provided an opportunity to correct erroneous information.

- C. **Department Chair**. The complete application will be reviewed by the Primary Hospital(s) appropriate Department Chair(s) for action. All applicable Department Chairs review the request for clinical privileges and make recommendations, including any conditions or comments.

Recommendations from the Department Chair and/or a peer shall refer to relevant training and experience, current competency, fulfillment of obligations in accordance with the Professional Staff Bylaws and the Policies and health status as it is applicable to the privileges requested.

- D. **OCC**. The OCC will make recommendations based on review of the complete application, recommendations of the Department Chair, and telephone contact for further information from references or other sources, as deemed necessary. The OCC makes recommendations to the MECs. The OCC's recommendations may include:
- 1) Approval of membership and clinical privileges;
  - 2) Approval with conditions;
  - 3) Deferral and request for further information;
  - 4) Denial of membership and/or clinical privileges.

E. **MEC.** The MEC reviews the OCC report and makes recommendations to the Board through the OMEC on matters pertaining to their Hospital. The MEC's recommendations may include:

- 1) Approval of membership and clinical privileges;
- 2) Approval with conditions;
- 3) Deferral and request for further information;
- 4) Denial of membership and/or clinical privileges.

F. **OMEC.** The OMEC reviews the MEC's recommendations and makes recommendations to the Board. Information contained in the complete application shall not be more than 180 days old at the time of the OMEC's review, except for information not subject to change from a prior application, such as verification of education and training verification and prior professional affiliations, which may be older than 180 days. The OMEC's recommendations may include:

- 1) Approval of membership and clinical privileges;
- 2) Approval with conditions;
- 3) Deferral and request for further information;
- 4) Denial of membership and/or clinical privileges.

If the OMEC recommends denial of membership and/or clinical privileges less than those applied for, the Chief Executive at the Primary Hospital, shall notify the applicant of the OMEC's recommendation. The notice shall inform the applicant of his/her right to a hearing and shall be accompanied by a copy of the Bylaws and Policies.

The applicant shall have 30 days after the date of the notice is sent to the applicant to request a hearing pursuant to Article X, (Fair Hearing Plan) of the Policies. If the applicant does not make a timely request for a hearing, the OMEC's recommendation shall be forwarded to the Chief Executive. If the applicant does request a hearing within the requisite period, the recommendation shall be stayed until a hearing is held and a final recommendation is forwarded to the Board.

G. **Board.** After receiving the recommendation of the OMEC, the Board shall, within 60 days, make its determination and communicate to the applicant, as to the acceptance, deferral or denial of the application and the scope of clinical privileges to be granted. Electronic voting may be utilized when deemed necessary. Under normal circumstances, determination will be made within 180 days of a complete application. The Chief Executive for Delivery System, or his designee, shall send notice of determination to the applicant. A denial of membership and/or clinical privileges will be sent by certified mail..

H. **Orientation**. All approved applicants will participate in a Virtual Orientation. Failure to complete the orientation within 60 days of appointment will be considered a voluntary resignation. As part of the Orientation, the practitioner will receive at least the following:

- 1) Information on the mission of PHSOR;
- 2) Professional Staff Policies and Procedures and Hospital policies pertinent to Members including, but not limited to: Advance Directives, Abuse Identification and Investigation, Central Line Placement, Deep Sedation, Determination of Brain Death, Emergency Medical Treatment & Labor Act (EMTALA), Moderate Sedation, Physician Restraints and Seclusion, Resuscitation and Emergency Intervention, Rights and Responsibilities of Patients, unusual Occurrence Reporting (DATIX), and Verbal and Telephone Orders.

J. **PH&S Photo Identification Badge**. The PH&S identification badge is required prior to exercising privileges. Identification will be verified prior to issuing an ID badge.

## **Section 6. Reappointment Process**

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

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

B. **Complete Application**. Additional information required for reappointment applications:

- 1) statistics showing clinical activity;
- 2) the Member's quality file containing assessment of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) as referenced in the Professional Staff Quality Review Policies and Procedures including, but not limited to: results of, focused studies, monitoring reports, drug use evaluations, complaints, incident reports, patient survey responses, correspondence regarding concerns, corrective or disciplinary actions, medical record delinquencies and suspensions.

## **Section 7. Expedited Appointment and Reappointment Approval Process**

Expedited credentialing approval provides an expedited review and approval process for initial appointment, reappointment and granting privileges when Board approved criteria are met. Applicants who do not meet the criteria for expedited credentialing approval will be processed through the normal credentialing process as specified in the Professional Staff Bylaws and Policies.

### **A. Criteria for Expedited Credentialing Approval**

1. The application is complete and accurate with all requested information returned as defined in Article V Section 5B.
2. The application contains no unexplained or alarming gaps in time.
3. No unresolved discrepancies, negative or questionable information has been received.
4. Medical staff/employment history is unremarkable.
5. The applicant's request for clinical privileges is consistent with his/her specialty, based on experience, training, and current competency, and meets applicable criteria.
6. The applicant has not received an involuntary termination of medical staff membership at another hospital.
7. The applicant has never withdrawn application for appointment, reappointment or resigned from the medical staff before a decision was made by another health care facility's governing board.
8. The applicant has never received an involuntary limitation, reduction, denial or loss of clinical privileges.
9. There are no current or previously successful challenges to licensure or registration, including DEA.
10. The applicant has never been named as a defendant in a criminal action and/or has never been convicted of a felony or misdemeanor (excluding misdemeanor traffic violations).
11. There are no significant adverse findings reported by the National Practitioner Data Bank.
12. There has not been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant

The Board will delegate to a committee, of at least two voting members, the authority to render determinations, as necessary, between regularly scheduled Board meetings.

The Department Chair will review each application that meets criteria for expedited credentialing approval and make a recommendation to move forward with the expedited review.

The OCC and MEC designees will review recommendations from the Department Chairs and make a recommendation to the Board designees.

## **Article VI. CLINICAL PRIVILEGES**

### **Section 1. Granting and Maintaining Clinical Privileges**

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

- A. **Appointment.** In the initial application for Professional Staff appointment, the applicant must request specific clinical privileges and meet the established privileging criteria as delineated on the privilege form. Recommendations for clinical privileges will be based on the applicant's evidence of meeting the established privileging criteria, education, training, experience, demonstrated current clinical competence, peer recommendations, health

- status as it impacts the privileges requested, and other relevant information. The applicant shall have the burden of demonstrating qualification and competency for the clinical privileges requested. Upon application for initial appointment applicants requesting privileges will undergo a Focused Professional Practice Evaluation (FPPE) of his or her performance. The scope of the FPPE shall be determined by the department chair or designee.
- B. **Reappointment.** Requests for clinical privileges at reappointment will be evaluated based on evidence of meeting the established privileging criteria as delineated on the privilege form, documented clinical activity, observation of care provided, conclusions drawn from performance improvement activities when available, in addition to the requirements of appointment as described above. Upon application for reappointment on or after the age of seventy (70), members requesting privileges will undergo a Focused Professional Performance Evaluation (FPPE) of his or her performance. The scope of the FPPE shall be determined by the department chair or designee.
- C. **Additions.** Members may apply for additional clinical privileges at any time. Such requests shall be submitted and processed in the same manner as the initial request. Temporary privileges may be granted after the Member has met the established privileging criteria and has been recommended by the Department Chair.
- D. **New.** If a Member requests a clinical privilege for which privileging guidelines have not been established, the Member is informed that the request cannot be processed until a determination is made that the procedure will be offered by the Hospital and privileging guidelines are established by the Board. Privileging guidelines are developed by a committee designated by the OCC and forwarded to the Board. This process will be completed as expeditiously as possible. Members granted privileges in new procedures are expected to assist in the training and proctoring of other Members.
- E. **Revisions.** The OCC will review and make recommendations to the OMEC and Board on all revisions to established privileging criteria.

## **Section 2. Temporary Privileges**

Temporary clinical privileges are granted in special circumstances. Special requirements for supervision and reporting may be imposed by the Hospital or the appropriate Department Chair on any practitioner granted temporary privileges. Practitioners granted temporary privileges must sign a statement agreeing to abide by the Professional Staff Bylaws, Policies, and applicable Hospital policies and procedures, sign a confidentiality agreement, and adhere to any requirements or restrictions applicable to temporary privileges. A temporary identification badge must be worn.

Time-limited temporary privileges, not to exceed one hundred twenty (120) days, may be granted under the following conditions by the Chief Executive or designee, acting on behalf of the Board, and with the recommendation of the appropriate Department Chair and President. Temporary privilege requests and supporting documentation should be submitted at least seven days in advance.

- A. **Application.** Temporary privileges may be granted to an applicant for membership and clinical privileges with a complete application as defined in Article VI, which reasonably supports a favorable determination. Under no circumstances may temporary privileges be granted if the application is pending because applicant has not responded to or provided requested information. A processing fee for administration of temporary privileges will not be assessed.
- B. **Specific Patient.** Temporary clinical privileges for the care of specific patients may be granted to a practitioner who is not an applicant. Primary source verification must be obtained which reasonably supports a favorable determination. Such temporary privileges shall be restricted to the treatment of specific patients and at the request of and under the responsibility of an Active Member who is designated as the attending physician or primary surgeon.

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

A processing fee for administration of temporary privileges, as set by the OMEC, will be assessed by the Hospital.

- C. **Specific Services.** Temporary privileges for time-limited, or patient-specific care, may be granted to a practitioner who is requested to provide a consulting or educational service by the President, or who possesses a unique expertise unavailable from the Professional Staff, or who is seeking additional mentoring or clinical experience with a Member. Documentation and Department Chair approval of mentoring or clinical experience plan is required when temporary privileges are requested for educational or mentoring purposes. Primary source verification must be obtained, which reasonably supports a favorable determination. A processing fee for administration of temporary privileges may be waived.
- D. **Disaster Privileges.** Temporary privileges may be granted to practitioners in the event of an emerging incident event and as directed by the Incident Command Center, when immediate patient needs are not being met. Emerging Incident Events include events that have potential to negatively impact the ability to provide services, such as, but not limited to, mass casualty incidents, earthquakes, bioterrorism, civil disturbance, fire, evacuation, hazardous material spill and/or utility failure. Primary source verification, which reasonably supports a favorable determination, must be obtained, as soon as possible. In cases where the complete verification process cannot be accomplished immediately, the Chief Executive or designee may grant temporary privileges for up to 72 hours upon presentation of a current PHSOR photo identification card or valid state or federal government-issued photo identification and at least one of the following: current hospital photo identification card with professional designation, copy of current state medical license, identification of membership in a recognized state or federal disaster in a Disaster Medical Assistance Team (DMAT) or other state or federal recognized organization engaged in pre-event credentialing, identification of federal, state or municipal entity authority to provide patient care, treatment, and services in disaster circumstances, or identification by current hospital staff or Professional Staff members with personal knowledge regarding the practitioner's ability to act as a licensed independent practitioner during a disaster. The Chief Executive or designee

may grant continuation of temporary privileges based on review of primary source verifications obtained and evidence of a demonstrated ability to continue to provide adequate care, treatment, and services. Non PHSOR practitioners will be paired with a Member. A processing fee for administration of temporary privileges will not be assessed.

- E. **Locum Tenens.** Temporary admitting and clinical privileges may be granted to a practitioner serving as a locum tenens for an Active Member. A completed, signed application approved by the appropriate Department Chair, is required and primary source verification must be obtained, which reasonably supports a favorable determination. A processing fee for administration of temporary privileges, as set by the OMEC, will be assessed by the Hospital.
- F. **Termination.** Temporary privileges may be terminated, reduced or modified on discovery of any information or occurrence of any event that places in question the practitioner's professional qualifications, ethical standing, or clinical competence, or when the life or well-being of a patient is in danger. Temporary privileges in a disaster are terminated as directed by the Incident Command Center or at the conclusion of the emerging incident event. In the event of such termination, patients will be assigned to a Member by the Department Chair or designee.

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

### **Section 3. Emergency Privileges**

An "emergency" is defined as a condition in which serious harm may result to a patient or in which the patient's life would be endangered by any delay in administering treatment.

In the case of emergency, any Member with clinical privileges, to the degree permitted by license and regardless of Department affiliation, status or clinical privileges, shall be permitted and expected to do everything possible to save the life of a patient or to save the patient from serious harm, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable.

### **Section 4. Telemedicine Credentialing by Proxy**

As provided in the Bylaws, Article VI, Section 5.5

## **Article VII. CLINICAL OR PROFESSIONAL CONDUCT CONCERNS / CORRECTIVE ACTION PLAN**

### **Section 1. Department Chair Review and Recommendation**

Issues of concern or written complaints regarding a Member's clinical or professional conduct are referred to the Department Chair for review and to the President for information. The Department Chair will review all pertinent information referenced in the Professional

Staff Quality Review Policies and Procedures, as applicable. Sexual harassment or misconduct complaints received from a Hospital employee or regarding a Hospital employee will be addressed by the Department of Human Resources according to Hospital policy, with notification to Department Chair.

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

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

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

- a) No further action;
- b) A documented informal discussion with the Member;
- c) A documented interview/special appearance (defined in Section 2);
- d) A focused review or investigation with documented findings (defined in Section 3);  
or
- e) Referral with recommendation to the MEC for review and possible action.

## **Section 2. Interview/Special Appearance**

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

- a) No further action;

- b) A focused review or investigation with documented findings (defined in Section 3);  
or
- c) Referral with recommendation to the MEC for review and possible action .

### **Section 3. Focused Review or Investigation**

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

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

### **Section 4. Review by MEC**

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

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

### **Section 5. Action by MEC**

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

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

### **Section 6. Action by OMEC**

Following review of the recommendations of the MEC, the OMEC shall make a recommendation to the Board to:

- a) Affirm the recommendation of the MEC;
- b) Modify the recommendation of the MEC by increasing or reducing the action recommended; or
- c) Reject the recommendation of the MEC. Such rejection shall have the effect of a remand to the MEC, which may then dismiss the matter or impose corrective action for which Board approval is not required.

### **Section 7. Action by Board**

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

### **Section 8. Zero Tolerance Policy**

There is a zero tolerance policy for the use of alcohol, controlled substances, and other intoxicants, which have an adverse effect on patient care or hospital operations as outlined below, while responsible for patient care in the Hospital.

The following steps will be taken if a Member comes to the Hospital to provide patient care, and the Member's behavior or physical condition or appearance raises a reasonable likelihood that, due to intoxication, (a) patient care or safety may be compromised, (b) Hospital operations may be disrupted, or (c) the community's confidence in the Hospital may be impaired. Examples of behavior, physical condition or appearance that may give rise to implementing this policy are, without limitation, alcohol on breath, slurred or incoherent speech, uncharacteristic moodiness, undue aggressiveness or disruptive conduct, and/or lack of coordination in fine or gross motor skill, i.e., writing, walking, etc.

Anyone who observes behavior or a physical condition or appearance of a Member in the Hospital that raises a question of impairment by a Member while responsible for patient care should immediately notify the nursing supervisor. Upon receipt of a complaint, the nursing supervisor will notify the Department Chair or designee such as a member of the MEC (the "Investigator"). The Investigator will proceed to the Hospital to investigate the complaint in accordance with Article VII of the Bylaws and Article VII of the Policies. Awaiting the arrival of the Investigator, the Nursing Supervisor does have the prerogative to hand patient care by the Member over to another qualified Member, in accordance with Hospital guidelines. As part of the investigation, the Member and/or the Investigator may request appropriate lab tests to determine evidence of chemical impairment.

Should testing be warranted the "Oregon Region – Employee Health & Ergonomics – for cause specimen collection process" will be initiated. The investigator will be considered the

manager/supervisor and the Member the employee for the purposes of these policies. The investigator will escort the Member to the testing site.

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

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

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

Upon receipt of a second complaint, the above process will be used except that the Investigator shall require appropriate lab testing of the Member and evaluation by an expert in substance abuse or other appropriate field (i.e., behavioral health). An investigation of a second complaint shall be referred to the OMEC in accordance with Article VIII, Section 6 of these Policies.

## **Article VIII. PRECAUTIONARY SUSPENSION**

### **Section 1. Imposition**

Whenever it is considered that action must be taken immediately in the interest of patient care, health and/or safety of any individual or to the orderly operation of the Hospital, any two of the following: OMEC Chair, MEC President, Department Chair, or Chief Executive shall have authority to suspend all or any portion of the clinical privileges of a Member. The Member may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation of the concerns raised. The precautionary suspension shall become effective immediately upon imposition. Notice of the precautionary suspension shall be promptly forwarded to the MEC, OMEC, Chief Executive, appropriate Hospital departments, and by certified mail, to the Member. The precautionary suspension shall be deemed an interim precautionary step in the professional review activity but is not a complete professional review action in and of itself. It shall not imply any final finding or responsibility for the situation that caused the suspension.

### **Section 2. Action by MEC**

Within seven days of a precautionary suspension, the MEC, shall recommend modification, continuance or termination of the terms of the precautionary suspension, and shall promptly notify the OMEC, OCC, Department Chair and the Chief Executive of its action. If the MEC recommends continuance or modification, the terms of the precautionary suspension as sustained or as modified shall remain in effect pending a decision by the OMEC and the

Board, acting through the Chief Executive.

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

### **Section 3. Action by OMEC**

Within seven days of receipt of the MEC recommendation for modification, continuance or termination of the terms of the precautionary suspension, the OMEC shall make a recommendation to the Board, acting through the Chief Executive. Notice to the Member of the recommendation of the OMEC shall be sent to the Member by certified mail. If the action is a recommendation, modification or continuation of the precautionary suspension, the notice shall advise the Member of his/her right to a hearing pursuant to the Fair Hearing Plan of these Policies, and shall be accompanied by a copy of the Bylaws and the Policies. All further action will be in keeping with the Fair Hearing Plan (Article X). If the OMEC recommends continuance or modification, the terms of the precautionary suspension as sustained or as modified shall remain in effect pending a decision by the Board acting through the Chief Executive.

If the OMEC does not recommend modification, continuance or termination within seven days of receipt of MEC's recommendation, the suspended Member shall automatically be reinstated to the status previously held.

### **Section 4. Action by Board**

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

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

### **Section 5. Continuity of Patient Care**

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

## **Article IX. AUTOMATIC SUSPENSION/LIMITATION**

## **Section 1. Imposition of Automatic Suspension**

Automatic suspension or limitation shall be initiated whenever there is revocation, suspension, restriction probation, or lapse of a Member's state license or DEA certificate; whenever a Member is excluded from participation in the Medicare, Medicaid or other Federal health care programs and is so listed on the Office of the Inspector General's List of Excluded Individuals/Entities; or Excluded Parties List System (EPLS); whenever there is failure to comply with OAR 333.505.0080, whenever there is failure to satisfy a special appearance requirement; whenever a Member fails to maintain malpractice insurance required by the Bylaws and these Policies; whenever a Member has been suspended in any way at any of the Hospitals. Hearing and appellate review rights do not apply to the imposition of automatic suspension/limitation. Notice of the automatic suspension or limitation shall be promptly forwarded to the MEC, OMEC, OCC, appropriate Hospital departments, Chief Executive and, by certified mail, to the Member. In the case of automatic suspension, the Member's elected and appointed office shall be automatically terminated.

### **1.2 State Professional License**

- A. Revocation: When a Member's license to practice in the state of Oregon is revoked, there is simultaneous and automatic revocation of Professional Staff membership and all clinical privileges. Upon reinstatement of the Member's license to practice, he/she must reapply for Professional Staff membership and clinical privileges.
- B. Restriction: During the period in which a Member's license is limited or restricted in any way, those clinical privileges that have been granted within the scope of the limitation or restriction are similarly limited or restricted, automatically, as of the date such action becomes effective and throughout its term. Upon reinstatement of the Member's license to practice without such restrictions or limitations, he/she must reapply for those clinical privileges that were limited or restricted.
- C. Suspension: If a Member's license is suspended, the Member's Professional Staff membership and clinical privileges are automatically suspended as of the date such action becomes effective. Upon reinstatement of the Member's license to practice, he/she must reapply for Professional Staff membership and clinical privileges.
- D. Probation: If a Member is placed on probation by the relevant licensing authority, his/her Professional Staff membership and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term. Upon termination of the probation, he/she must reapply for membership and the clinical privileges that were subject to the probation.
- E. Lapse: If a Member's license to practice in the state of Oregon lapses due to failure to complete the renewal process, the Member's Professional Staff membership and clinical privileges are automatically suspended as of the date of such action. The Member may be reinstated within two weeks of the date of such action when proof of current licensure is provided to the Medical Staff Office with a reasonable written explanation of the Member's failure to maintain state licensure. If a Member fails to provide proof of state licensure and reasonable explanation within the two week period, Professional Staff membership and

Privileges shall be suspended and he/she must reapply for Professional Staff membership and clinical privileges.

### **1.3. Drug Enforcement Administration (DEA) Certificate**

- A. Revocation, Restriction, Suspension, Probation: If a Member's right to prescribe controlled substances is revoked, restricted, suspended or placed on probation by a proper licensing authority, the ability to prescribe such substances in the Hospital will also be revoked, restricted, suspended or placed on probation automatically, if applicable to Hospital practice. Upon reinstatement of the Member's DEA certificate, he/she must reapply for Professional Staff membership and clinical privileges as applicable.
- B. Lapse: If a Member's right to prescribe controlled substances lapses the ability to prescribe such substances in the Hospital will also lapse. Upon reinstatement of the Member's DEA certificate, the ability to prescribe controlled substances in the Hospital will be reinstated. If a Member fails to provide proof of a current DEA certificate and/or a reasonable explanation to the Medical Staff Office within the two week period, Professional Staff membership and Privileges shall be suspended and he/she must reapply for Professional Staff membership and clinical privileges.

### **1.4. Professional Liability Insurance**

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

### **1.5. Tuberculosis Testing**

- A. Member's Professional Staff membership and clinical privileges are immediately suspended for failure to comply with Tuberculosis (TB) testing requirements as set forth in the OAR 333-505-0080 to include:
- B. Obtaining documentation that baseline TB testing has been conducted in a manner consistent with the CDC guidelines for any person who enters a hospital and who has contact with patients, enters rooms that patients may enter, or who handles clinical specimens or other material from patients or their rooms.
- C. Complying with serial testing requirement in the CDC guidelines, based on the risk level of the Hospitals.

The Member may be reinstated within seven days of the date of the notice of suspension when proof of required TB testing is provided to the Medical Staff Office with a reasonable written explanation of the Member's failure to obtain TB testing as required. If a Member fails to provide proof of TB testing and reasonable explanation within the seven-day period,

Professional Staff membership and privileges shall be suspended and he/she must reapply for Professional Staff membership and clinical privileges.

## **1.6 Medicare, Medicaid or other Federal Health Care Exclusion**

If a Member is excluded from participation in the Medicare, Medicaid or other Federal health care programs and is so listed on the Office of the Inspector General's List of Excluded Individuals/Entities; or Excluded Parties List System (EPLS); they will be immediately suspended. Upon reinstatement of ability to participate in Medicare, Medicaid or other Federal health care programs he/she may reapply for Professional Staff membership and clinical privileges.

## **1.7 Hospital Suspension**

If a Member's clinical privileges are suspended in any way at any one of the Hospitals, the Member's clinical privileges are automatically suspended as of the date such action becomes effective at the other Hospitals. Upon reinstatement of the Member's clinical privileges, he/she must reapply for those privileges at the other Hospitals.

## **Section 2. Continuity of Patient Care**

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

## **Article X. FAIR HEARING PLAN**

### **Section 1. Definitions**

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

- A. "Appellate review committee" means the group designated under this Plan to hear an appeal properly requested and pursued by an Affected Practitioner.
- B. "Adverse action or recommendation" means any one of the events listed in Section 2(A)(1) of this Plan, which has been recommended or approved for forwarding to the Board by the MEC/OMEC, or which has been taken by the Board under circumstances in which no prior right to request a hearing existed. For purposes of this Plan, an adverse action or recommendation is not final until it has been adopted as final action by the Board after the Practitioner has had the opportunity of a hearing under this Plan.
- C. "Affected Practitioner" means the applicant or Member subject to the adverse action or recommendation.
- D. "Board" means the Oregon Community Ministry Board, which has oversight over the Hospitals in the Oregon Region, as described in its Bylaws.

- E. "Chief Executive" means the individual appointed by the Board to act on its behalf in the management of each Hospital.
- F. "Hearing committee" means the committee appointed under this Plan to preside over a hearing properly requested and pursued by an Affected Practitioner.
- G. "Hearing Officer" means an individual appointed to conduct the hearing.
- H. "Notice" means any communication or notice required by this Plan and may be sent in multiple methods as described under "Notice" definition of the PHSOR Policies and Procedures, Article I. Definitions.
- I. "Party" or "parties" means the Affected Practitioner who requested the hearing or appellate review and the body or bodies who participate in the hearing or appellate review.

## **Section 2. Initiation of Hearing**

### **A. Triggering Events:**

1. The following MEC/OMEC recommendations with respect to an Affected Practitioner shall be grounds for a hearing:
  - a. denial of initial Professional Staff appointment;
  - b. denial of Professional Staff reappointment;
  - c. revocation of Professional Staff appointment;
  - d. reduction of clinical privileges;
  - e. suspension of clinical privileges for more than 30 days (other than precautionary suspension);
  - f. precautionary suspension of clinical privileges that lasts longer than 14 days;
  - g. revocation of clinical privileges; and
  - h. restriction on the exercise of privileges, including the imposition of mandatory consultation/proctoring requirement.
2. For ease of use, this Plan refers to adverse recommendations of the MEC/OMEC. The Board may take any of the above actions without an adverse recommendation by the MEC/OMEC, and in that case, the Affected Practitioner would also be entitled to request a hearing. When a hearing is triggered by an action of the Board, any reference in this Plan to the "MEC/OMEC" shall be interpreted as a reference to the "Board."

### **B. Automatic Actions:**

1. An action that is administrative in nature or otherwise an automatic result of a circumstance as described in these Policies and Procedures is not a professional review action and is not grounds for a hearing. Actions not grounds for a hearing include, but are not limited to:

- a. applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;
- b. ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Professional Staff development plan or is covered under an exclusive provider agreement; failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;
- c. application is incomplete or untimely;
- d. application shall not be processed due to a misstatement or omission;
- e. change in assigned staff category or when the member is not eligible for a specific staff category;
- f. expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- g. automatic relinquishment of appointment or privileges or automatic resignation;
- h. removal from the on-call roster or any other reading panel;
- i. withdrawal of temporary privileges; and
- j. termination of any contract with or employment by the Hospital.

C. When Deemed Adverse:

1. A recommendation or action listed in Section 2. A, Triggering Events, is adverse only when it relates to the clinical competence or professional conduct of the Affected Practitioner and has been:
  - a. recommended by the MEC and concurred by the OMEC; or
  - b. taken by the Board.

D. Notice of Adverse Recommendation or Action:

1. The Chief Executive promptly gives the Affected Practitioner notice of an adverse recommendation or action. The notice shall:
  - a. advise the Affected Practitioner of the recommendation or action, the reasons and the right to request a hearing pursuant to the provisions of the Policies and Procedures and this Plan;
  - b. summarize the rights of the Affected Practitioner in the hearing;
  - c. specify that the Affected Practitioner has 30 days after the effective date of notice within which to submit a request for a hearing;
  - 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 after receipt of the Affected Practitioner's hearing request, the Chief Executive will notify the Affected Practitioner of the date, time and place of the hearing;
  - f. state that if the Affected Practitioner chooses to have representation by an attorney, the Affected Practitioner must so notify the Chief Executive in writing at least five days before the hearing; and
  - g. include a copy of this Plan.
2. Request for Hearing: The Affected Practitioner shall have 30 days after the date of the notice is sent to Affected Practitioner to request a hearing. The request must be delivered, in writing, to the Chief Executive.
  3. Waiver by Failure to Request a Hearing: An Affected Practitioner who fails to request a hearing within 30 days after the effective date of the notice to request a hearing will lose the right to any hearing or appellate review. The adverse recommendation shall then be referred to the Board for final action. The Chief Executive will send the Affected Practitioner notice of referral to the Board.

### **Section 3. Hearing Prerequisites**

- A. Notice and Time and Place for Hearing: When a proper request for a hearing is received, the Chief Executive shall deliver it to the Medical Staff Office and notify the MEC and OMEC. The Medical Staff Office shall arrange and schedule a hearing, and the Chief Executive will send the Affected Practitioner notice of the time, place and date of the hearing.
- B. Statement of Issues, Events, and Witnesses: The notice of hearing must contain a concise statement of the Affected Practitioner's alleged acts or omissions, a list by number of the specific patient records in question, and any other reasons or subject matter forming the basis for the adverse action or recommendation. In addition, the notice shall include a proposed list of the witnesses (if any) expected to testify at the hearing in support of the adverse recommendation or decision. This statement, the potential witness list, and the list of supporting patient record numbers and other information it contains, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the Affected Practitioner requesting the hearing, and notice of the change is promptly given to the other party.
- C. Witness List: The Affected Practitioner requesting the hearing shall provide a written list of the names and addresses of the individuals expected to testify on the Affected Practitioner's behalf within 10 days after effective date of the notice of the hearing. The witness list may, in the discretion of the hearing officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is promptly given to the other party.
- D. Hearing Date: The hearing date shall not be less than 30 days or more than 45 days after the date of the request for a hearing, unless an earlier hearing date has been specifically

agreed in writing by the parties.

#### **Section 4. Hearing Committee, and Hearing Officer, and Attorneys**

A. Hearing Committee: The Chief Executive shall confer with the President of the Professional Staff and appoint a hearing committee composed of three health professionals, which may include any combination of:

1. Any member of the Professional Staff, provided that the member has not actively participated in the matter any previous level; and/or
2. Practitioners not connected with the Hospital.

Knowledge of the underlying peer review matter, in and of itself, shall not preclude a Practitioner from serving on the Committee.

Employment by, or other contractual arrangement, with the Hospital shall not preclude a Practitioner from serving on the Committee.

None of the members of the hearing committee may be in direct economic competition with the Affected Practitioner.

The members of the hearing committee must give fair and impartial consideration of the case. The hearing committee shall not include any Practitioner who is demonstrated by the Affected Practitioner to have an actual bias, prejudice, or conflict of interest that would prevent the Practitioner from fairly and impartially considering the matter.

The President of the Professional Staff where the action was initiated shall designate one of the appointees as Chair of the hearing committee.

B. Hearing Officer: The Chief Executive shall confer with the President of the Professional Staff and appoint a hearing officer. A hearing officer may or may not be an attorney but must be experienced in conducting hearings. Attorneys who are otherwise involved in the hearing are not eligible to be the hearing officer. A hearing officer may not vote and may not be in direct economic competition with the Affected Practitioner.

1. The Hearing Officer shall:
  - a. Allow participants in the hearing to have reasonable opportunity to be heard and present evidence, subject to reasonable limits on the number and order of witnesses and duration of direct and cross-examination.
  - b. Maintain decorum throughout the hearing.
  - c. Rule on all matters of procedure and the admissibility of evidence.

- d. Conduct argument by counsel on procedural points within or outside the presence of the hearing committee, at the Hearing Officer's discretion.
  - e. Forbid irrelevant, excessive, or abusive presentation of evidence causing undue delay.
2. The hearing officer may consult with legal counsel to the Hospital about hearing procedure.
  3. The hearing officer may participate in the private deliberations of the hearing committee and be advisor to it, but shall not be entitled to vote on its recommendations.
- C. Attorneys: Either party may be represented by an attorney for purposes of the hearing and/or appellate review, provided that the party notifies the other party at least five days in advance of the hearing or appellate review. If an Affected Practitioner elects to be represented by an attorney, he/she will be solely responsible for payment of all his/her attorney fees no matter which party prevails at the hearing or conclusion of the appellate review.

## **Section 5. Pre-Hearing Process**

- A. No right to discovery or contact witnesses: The pre-hearing and hearing process shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply. Neither party has the right to issue subpoenas or discovery requests, depose, interrogate, or interview witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process. Neither the Affected Practitioner who has requested the hearing, nor any other person acting on behalf of the Affected Practitioner, may contact Hospital employees or Professional Staff members whose names appear on the witness list or in documents provided pursuant to the hearing concerning the subject matter of the hearing, unless and until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the Affected Practitioner who has requested the hearing once it has contacted such employees or Professional Staff members and confirmed their willingness to meet. Any employee or Professional Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.
- B. Confidential Information: The Affected Practitioner requesting the hearing must agree that all documents and information disclosed before, during, or after the hearing are confidential and shall not be disclosed or used for any purpose outside of the hearing. The Affected Practitioner must agree to maintain the information in a confidential manner. Upon receipt of the agreement and representation, the Affected Practitioner requesting the hearing shall be provided with a copy of the following:
- a. Copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the Affected Practitioner's expense.
  - b. Reports of experts relied upon by the MEC;

- c. Copies of relevant minutes (with portions regarding other practitioners and unrelated matters deleted); and
- d. Copies of any other documents relied upon by the MEC.

The provision of this information is not intended to and does not waive any privilege under the state peer review protection statutes.

- C. Pre-Hearing Conference: The Hearing Officer shall require the Affected Practitioner or his/her attorney and the MEC/OMEC or their representative (who may be the attorney) to participate in the pre-hearing conference, which shall be held no later than seven days prior to the hearing. The Hearing Officer shall resolve all procedural questions, including any objections to the exhibits and witnesses. The parties and their attorneys, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.
- D. Information to the Hearing Committee: The following documents shall be exchanged by the parties and provided to the Hearing Committee in advance of the hearing:
  - a. pre-hearing statement that either party may choose to submit;
  - b. exhibits offered by the parties; and
  - c. any stipulations agreed to by the parties.

## **Section 6. Hearing Procedure**

- A. Personal Presence: The personal presence of the Affected Practitioner is required at the hearing. The hearing shall be restricted to those parties involved in the proceedings and their attorneys, the President of the Professional Staff or designee, the Chief Executive or designee, and administrative personnel as requested by the Chief Executive. An Affected Practitioner who fails, without good cause, to appear and respond to questions at the hearing shall lose his/her right to a hearing or appellate review.
- B. Rights of Parties: At the hearing, both sides have the following rights, subject to reasonable limits and timing as determined by the Hearing Officer:
  - 1. Call and examine witnesses;
  - 2. Introduce exhibits;
  - 3. Cross-examine any witness on any matter relevant to the issues. If the Affected Practitioner does not testify on his/her own behalf he/she may be called and examined as if under cross-examination; and
  - 4. Submit pre- or post-hearing memoranda, which may include proposed findings, conclusions and recommendations to the Hearing Committee.

- C. Procedure and Evidence: The hearing shall not be conducted according to rules of evidence. Any relevant evidence upon which responsible persons might customarily rely on in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. The committee is also entitled to consider all other relevant information that can be considered in connection with credentialing matters. The Hearing Committee may question witnesses, request the presence of additional witnesses, and/or request documentary evidence. Each party may submit memoranda concerning any issue of law or fact, prior to, during, or at the close of the hearing, and those memoranda shall become part of the hearing record. Oral evidence shall be taken only on oath or affirmation.
- D. Order of Evidence: The party whose adverse action or recommendation gave rise to the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. Thereafter, the burden shall shift to the Affected Practitioner who requested the hearing to present evidence in response.
- E. Hearing Record: A stenographic reporter shall be present to record the hearing. The hearing record shall also contain all exhibits or other documentation considered written statements submitted by the parties, and correspondence between the parties or between the hearing committee and the parties, if any, during the hearing process. The Affected Practitioner may request a copy of the hearing transcript at his/her own expense. The transcript, like all information created or disclosed during the hearing process, is confidential and may not be used for any purpose other than the hearing pursuant to this Plan.
- F. Postponement: Requests for postponement of a hearing may be granted by the Hearing Officer only upon a showing of good cause and only if the request is made as soon as is reasonably practical.
- G. Presence of Hearing Committee: The entire hearing committee must be present throughout the hearing and deliberations. In rare instances when a hearing committee member must be absent from any portion of the hearing, he/she shall read the entire transcript of the portion of the hearing from which he/she was absent.
- H. Compensation: The Hearing Committee and/or Hearing Officer may be compensated by the Hospital, but the Affected Practitioner requesting the hearing may participate in any such compensation should the Affected Practitioner wish to do so.

## **Section 7. Committee Deliberation and Recommendation**

- A. Hearing Committee Recommendation: After all the evidence has been submitted, the hearing committee shall recommend in favor of the MEC/OMEC or the Board unless it finds that the Affected Practitioner who requested the hearing has proven by clear and convincing evidence that the adverse action or recommendation that prompted the hearing was arbitrary, capricious, or not supported by reasonable evidence.
- B. Deliberation and Recommendation of the Hearing Committee: Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The hearing committee shall, within 10 days of the hearing, conduct its deliberations

outside the presence of the parties except the Hearing Officer. Upon conclusion of its deliberations, the hearing committee shall make a written report of its findings and recommendation, and shall forward the report along with the record and other documentation to the MEC/OMEAC. The Chief Executive shall promptly send notice of the hearing committee's recommendation to the Affected Practitioner, along with a copy of the hearing committee report.

## **Section 8. Initiation and Prerequisites for Appellate Review**

- A. Request for Appellate Review: Either party shall have 10 days after the notice of the hearing committee's recommendation to request an appeal. The request shall be in writing, delivered to the Chief Executive, and include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the hearing committee's report and recommendation shall be forwarded to the Board for final action.
1. Grounds for Appeal: The grounds for appeal shall be limited to the following:
- a. There was substantial failure by the hearing committee to comply with this Plan and/or Professional Staff Policies and Procedures and Bylaws during the hearing so as to deny a fair hearing; and/or
  - b. The recommendations of the hearing committee were made arbitrarily or capriciously and/or were not supported by reasonable evidence.
- B. Notice of Time and Place for Appellate Review: The Chief Executive shall schedule and arrange for an appellate review that shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved. At least 10 days prior to the appellate review, the Chief Executive shall send the Affected Practitioner notice of the time, place and date of the review. If the Affected Practitioner wishes to be represented by an attorney at any appellate review, he/she must so notify the Chief Executive at least five days prior to the appellate review.
- C. Appellate Review Committee: The Chief Executive 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 Active Staff who are not in direct economic competition with the Affected Practitioner, two who shall be members of the Board, and one who shall be a representative of PHSOR administration. No member appointed to the appellate review committee shall be a person who has participated in earlier proceedings in the case.

## **Section 9. 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, and the written statements if any submitted. The purpose of appellate review is to review the record of earlier proceedings to determine if the recommendations and the action taken (1) involve compliance with Professional Staff Policies and Procedures and Bylaws, (2) are not arbitrary or capricious, and (3) are supported by reasonable evidence.

- B. Written Statements: Either party may submit a written statement containing objections to the findings, actions, and procedural rulings or any matter relevant to the appeal. The statement shall be submitted to the appellate review committee and the other parties through the Chief Executive at least 10 days prior to the scheduled date of the review, except if the time limit is waived by the appellate review committee.
- C. 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 posed by the appellate review committee.
- D. Consideration of New or Additional Matters: New or additional evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the appellate review committee as it 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 Chief Executive a written description of the new or additional evidence as soon as it becomes aware of the evidence, but in no event later than five days prior to the scheduled date of the review. The Chief Executive shall immediately transmit the description to the appellate review committee and the other party.
- E. Presence of Committee Members and Vote: All members of the appellate review committee must be present throughout the review and deliberations.
- F. Adjournments: At the conclusion of the oral statements, if allowed, the appellate review shall be closed. The appellate review committee shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review committee shall be adjourned at the conclusion of those deliberations.
- G. Action by Appellate Review Committee: The appellate review committee may recommend that the Board affirm, modify or reverse the adverse recommendation or action. The appellate review committee shall promptly forward a report containing its recommendation, the hearing record, and all documentation to the Board. The Chief Executive will send notice to the Affected Practitioner of the appellate review committee's determination, along with a copy of the report.
- H. Final Action:
  - 1. Action by Board: The Board shall act within 30 days after the matter is referred to the Board as described in Section 2. D. (waiver), Section 8. A. (failure to request appellate review), or Section 8. C. (appellate review committee determination) of this Plan. The Board may review any information that it deems relevant, including but not limited to: the findings and recommendations of the MEC/OMECE, Hearing Committee, and/or Appellate Review Committee. The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer back the matter for further review and recommendation, or make its own decision based upon the Board's ultimate responsibility for the operation of the Hospital and the quality of care provided. If the matter is referred

back, any recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

The Board shall render its final decision in writing, including specific reasons, and shall forward the report to the MEC/OMEC. The final decision of the Board shall be effective immediately and shall not be subject to further review.

The Chief Executive shall send notice to the Affected Practitioner of the Board's decision, along with a copy of the Board's report.

## **Section 10. General Provisions**

- A. Number of Hearings and Review: No Practitioner is entitled to request more than one hearing and one appellate review with respect to the adverse recommendation or action triggering the right. If the final action is denial of initial appointment or reappointment to the Professional Staff, or revocation of membership and/or clinical privileges of a current Practitioner of the Professional Staff, that Practitioner may not apply for staff membership and/or for those clinical privileges for a period of five years unless the Board provides otherwise.
- B. Confidentiality: All verbal and written communications, disclosures, information, correspondence, statements, documents, testimony, records, or anything else exchanged, referred to, or disclosed under this Plan is confidential and may not be used for any purpose other than as directed in this Plan.

## **Article XI. PROFESSIONAL STAFF ASSISTANCE PROGRAM**

### **Section 1. Early Assistance Program**

The Professional Staff is committed to providing programs, resources and education to enhance physical and emotional well-being of Members and their families. Healthy Members are fundamental to quality patient care, more productive and enhance the work environment. With this in mind the Professional Staff offers Members assistance and support through a program that provides confidential assessments, counseling and referral services.

The Professional Staff Early Assistance Program is available to all Members and families for self-referral and includes twenty-four hour, seven days/week availability for assessment and triage, family support, education and consultation services. If ongoing treatment is appropriate, referral is made to the appropriate provider in the community.

All employees and Professional Staff Members are strongly encouraged to express concerns about a Member's health and to make a referral to the President, Department Chair or the Medical Staff Office. The concern will be reviewed following the Clinical or Professional Conduct Concerns/Corrective Action Plan (Article VII). Confidentiality and peer review protection of the Professional Staff Member referred for assistance or self-referred will be maintained according to PH&S and PHSOR Professional Staff confidentiality policies (Article V, Section 1, F) and by applicable laws of the State of Oregon.

## **Section 2. Assistance for Impaired Members**

The term "impaired professional" is used to describe the practitioner who is prevented by reasons of illness or other health problems from performing professional duties at the expected level of skill and competency. Impairment also implies a decreased ability and/or willingness on the part of the affected individual to acknowledge the problem or to seek help to recover. This places the professional at risk and may pose an actual or potential risk to public health and safety. Most conditions of impairment are treatable illnesses. The Professional Staff Early Assistance Program and/or the Professional Staff Health Committee and/or the Clinical or Professional Conduct Concerns/Corrective Action Plan (Article VII) are available as appropriate to help identify any impairing condition that might exist, assure availability of treatment and rehabilitation services and support the return to active work status.

The Oregon Health Professional Services Program (HPSP) is available to Members if impairment is suspected. Services provided by the HPSP include assessment, treatment, support and monitoring to facilitate recovery and return to work. It is the policy of the Professional Staff that referral of a Member suspected of impairment be made to the Professional Staff Health Committee or directly to the HPSP. The Professional Staff Health Committee and/or the Department Chair, following the Clinical or Professional Conduct Concerns/Corrective Action Plan (Article VII), in conjunction with the HPSP, will arrange for assessment, treatment support and monitoring to facilitate recovery and appropriate return to work.

## **Article XII. HOSPITAL SPECIFIC DEPARTMENTS OF THE PROFESSIONAL STAFF**

Department meetings shall be held as often as necessary to accomplish the patient care and education goals of the Department. A record of the proceedings shall be maintained and reports forwarded to the MEC. In accordance with Article X, Section 2 of the Bylaws, the Chair of a Department shall be appointed by the President with the input of the Active Members of the Department and the concurrence of the OMEC, the MEC and the Chief Executive, except as specified by contract or as otherwise noted. Department specific responsibilities may be identified by individual departments with approval of the MEC and OMEC.

### **Section 1. PHRMH:**

- A. Emergency Medicine: Members shall include all emergency medicine services in the Hospital.
- B. Medicine/ICU: Members shall include allergy/immunology, cardiology, Family Medicine, gastroenterology, hematology/oncology, internal medicine, nephrology, neurology, physical medicine rehab, psychiatry, pulmonary services and other sub-specialties of Internal Medicine which may be represented on the staff in the future. The Medicine Use/Pharmacy & Therapeutics Committee is a sub-committee of the Medicine/ICU Committee.
- C. Obstetrics/Pediatrics: Members shall include all obstetric, gynecology, pediatric, and reproductive endocrinology & infertility services in the Hospital.

- D. Surgery: Members shall include anesthesiology, general surgery, gynecologic surgery, neurological, ophthalmology, oral, orthopedic, otolaryngology, pathology, plastic, podiatry, surgical oncology and urology services in the Hospital.
- E. Radiology: Members shall include radiology, and radiation oncology services in the Hospital.

## **Section 2. PMMC**

- A. Emergency Medicine: Members shall include emergency medicine services and other sub-specialties of Emergency Medicine which may be represented on the staff in the future.
- B. Medicine: Members shall include allergy/immunology, cardiology, family medicine, gastroenterology, hematology/oncology, internal medicine, nephrology, neurology, pathology, physical medicine rehab, radiology, psychiatry, and pulmonary services.
- C. Surgery: Members shall include anesthesiology, neurological, ophthalmology, oral surgery, orthopedic, otolaryngology, plastic, podiatry, surgical oncology and urology services.
- D. Women's and Children's Health: Members shall include obstetrics, gynecology, pediatrics and neonatology and any other sub-specialties of Women's and Children's Health which may be represented on the staff in the future.

## **Section 3. PMH**

- A. Anesthesiology: Members shall include all anesthesiology services in the Hospital. These services are conducted under exclusive contract.
- B. Emergency Medicine: Members shall include all emergency medicine services in the Hospital. These services are conducted under exclusive contract.
- A. Family and Internal Medicine: Members shall include allergy/immunology, cardiology, dermatology, family medicine, gastroenterology, geriatrics, hematology/oncology, infectious disease, internal medicine, nephrology, neurology, physical medicine rehab, rheumatology, and pulmonology services in the Hospital.
- D. Pathology: Members shall include all pathological anatomy, clinical laboratory and transfusion services in the Hospital. These services are conducted under exclusive contract.
- E. Diagnostic Imaging: Members shall include all radiological services in the Hospital. These services are conducted under exclusive contract.
- F. Surgery: Members shall include cardiovascular/thoracic, general/vascular, gynecology, neurological, ophthalmology, oral, orthopedic, otolaryngology, plastic, podiatry, surgical oncology and urology services in the Hospital.

G. Psychiatry: Members shall include all behavioral health services providers in the Hospital.

#### **Section 4. PPMC**

A. Emergency Medicine: Members shall include all emergency medicine services in the Hospital.

B. Medicine: Members shall include allergy/immunology, cardiology, dermatology, family medicine, gastroenterology, hematology/oncology, internal medicine, nephrology, neurology, psychiatry, psychology radiology, rheumatology and pulmonary services.

C. Obstetrics/Pediatrics: Members shall include all obstetrics, gynecology and pediatrics services in the Hospital.

D. Surgery: Members shall include anesthesiology, general/vascular, neurological, ophthalmology, oral, orthopedic, otolaryngology, pathology, plastic, podiatry, surgical oncology and urology services in the Hospital.

Anesthesiology, Emergency Medicine, Pathology and Radiology services are conducted under exclusive contract.

#### **Section 5. PPMC**

At PPMC, clinical departments will be organized into Divisions and Departments per Bylaws Article X, Section 1.2. There may be one or more Departments within a Division.

The Division Chiefs of Medicine, Surgery, Ambulatory Medicine, and the Department Chairs of Anesthesia, Emergency Medicine, Hospitalist, Pathology, Psychiatry, and Radiology are appointed by the Chief Executive, with input from the MEC, and serve until a replacement is named.

All other Department Chairs shall be appointed by the President of the Professional Staff for the Hospital with the input from the Active members of the department and the concurrence of the Division Chief, OMEC, the MEC and the Chief Executive.

The Division Chief oversees and facilitates the execution of the Department Chair's responsibilities as outlined in Article XII, Section 5 of these Policies and Article X of the Bylaws.

A. Anesthesiology: Members shall include all anesthesiology services in the Hospital. These services are conducted under exclusive contract.

B. Cardiology: Members shall include all cardiology services in the Hospital.

C. Emergency Medicine: Members shall include all emergency medicine services in the Hospital. These services are conducted under exclusive contract.

- D. Family Medicine: Members shall include family medicine and general practice services in the Hospital.
- E. Gastroenterology: Members shall include all gastroenterology services in the Hospital.
- F. Hematology/Oncology: Members shall include all medical oncologic services in the Hospital.
- G. Hospitalist: Members shall include all Hospitalist services in the Hospital. These services are conducted under exclusive contract.
- H. Medicine: Members shall include allergy/immunology, dermatology, endocrinology, infectious diseases, internal medicine, nephrology, neurology, physical medicine and rehabilitation, occupational medicine and rheumatology services in the Hospital.
- I. Neurosurgery: Members shall include all neurosurgical services in the Hospital.
- J. Obstetrics, Gynecology and Pediatrics (OB/GYN/PEDS): Members shall include all obstetrics, gynecology, pediatrics and neonatology services in the Hospital.
- K. Orthopedics: Members shall include all orthopedic surgery services in the Hospital.
- L. Pathology: Members shall include pathological anatomy, clinical laboratory, transfusion and services in the Hospital. These services are conducted under exclusive contract.
- M. Podiatry: Members shall include all podiatry services in the Hospital.
- N. Psychiatry: Members shall include all behavioral health services in the Hospital.
- O. Pulmonology: Members shall include all pulmonology services in the Hospital.
- P. Radiology: Members shall include interventional radiology, medical diagnostic imaging, radiological and nuclear medicine, and radiation oncology services in the Hospital. These services are conducted under exclusive contracts.
- Q. Surgery: Members shall include cardiovascular/thoracic, general/vascular, neurological, ophthalmology, oral, otolaryngology, plastic, and podiatry surgery services in the Hospital.
- R. Urology: Members shall include urology services in the Hospital.

## **Section 6. PSH**

- A. Emergency Medicine: Members shall include all emergency medicine services in the Hospital.
- B. Medicine: Members shall include allergy/immunology, cardiology, dermatology, family medicine, gastroenterology, hematology/oncology, internal medicine,

nephrology, neurology, pediatric, physical medicine rehab, radiology, psychiatry and pulmonary services.

- C. Surgery: Members shall include anesthesia, dental, general surgery, gynecology, neurosurgery, obstetrics, ophthalmology, oral, orthopedic, otolaryngology, pathology, plastic, podiatry, surgical oncology and urology services in the Hospital.

## **Section 7. PSVMC**

At PSVMC, clinical departments will be organized into Divisions and Departments ~~and~~ per Bylaws Article X, Section 1.2. There may be one or more Departments within a Division.

The Division Chiefs of Medicine, Surgery, Women's and Children's, and the Department Chairs of Emergency Medicine, Pathology, Radiology and Radiation Oncology are appointed by the Chief Executive, with input from the MEC, and serve until a replacement is named.

All other Department Chairs shall be appointed by the President of the Professional Staff for the Hospital with the input from the Active members of the department and the concurrence of the Division Chief, OMEC, the MEC and the Chief Executive. Department Chairs generally serve a two-year term commencing February 1.

The Division Chief oversees and facilitates the execution of the Department Chair's responsibilities as outlined in Article X, Section 2 of the PHSOR Bylaws. The Department Chairs are expected to provide input on credentialing, privileging, quality management and improvement and other matters relating to their specialty.

- A. Medicine Division: Function of the Department is the responsibility of the Department Chair, but the Division Chief of Medicine retains authority and responsibility. The departments under the division of Medicine include: Emergency Medicine (including Urgent Care, Cardiology, Family Medicine, Gastroenterology, Hematology/Oncology, Internal Medicine, Nephrology, Neurology (including Physical Medicine and Rehab), Psychiatry (including Psychology), Pulmonology (including Intensivists), and Radiology (including Medical Diagnostic Imaging, Radiology, Nuclear Medicine, and Radiation Oncology).
- B. Surgery Division: Functions of the Departments are the responsibility of the Department Chair, but the Division Chief of Surgery retains authority and responsibility. The departments under the Division of Surgery include: Anesthesia, Cardiothoracic surgery, General/Vascular surgery (including colo-rectal surgeons), Neurosurgery, Ophthalmology, Oral/Maxillary/Facial, Orthopedics, Otolaryngology, Pathology, Pediatric Surgery, Plastic Surgery, Podiatry, and Urology.
- C. Women's and Children's Division: Functions of the Departments are the responsibility of the Department Chair, but the Division Chief of Women's and Children's retains authority and responsibility. The departments under the Division of Women's and Children's include: Gynecology, Obstetrics, Neonatal Intensive Care, and Pediatrics.

- D. Anesthesiology: Members shall include all anesthesiology services (including Pain Management) in the Hospital. With the exception of pain management, these services are conducted under exclusive contract.
- E. Cardiology: Members shall include all Cardiology services in the Hospital.
- F. Cardiothoracic Surgery: Members shall include all Cardiothoracic surgery services in the hospital.
- G. Emergency Medicine: Members shall include all emergency medicine services (including Urgent Care) in the Hospital. With the exception of urgent care, these services are conducted under exclusive contract.
- H. Family Medicine: Members shall include family medicine and general practice services in the Hospital.
- I. Gastroenterology: Members shall include Gastroenterology services in the hospital.
- J. General/Vascular Surgery: Members shall include General and Vascular surgery services (including colo-rectal surgery) provided in the hospital.
- K. Gynecology: Members shall include Gynecology services in the hospital.
- L. Hematology/Oncology: Members shall include Hematology and Oncology services in the hospital.
- M. Hospitalist: members shall include all adult internal medicine Hospitalist services in the Hospital. These services are conducted under exclusive contracts.
- N. Internal Medicine: Members shall include Internal Medicine, Dermatology, Palliative Care, Endocrinology, Infectious Disease, and Rheumatology services in the hospital.
- O. Nephrology: Members shall include Nephrology services in the hospital.
- P. Neurology: Members shall include neurological services in the hospital.
- Q. Neurosurgery: Members shall include neurosurgical services in the Hospital.
- R. Neonatal: Members shall include Neonatology services provided in the Hospital.
- S. Obstetrics: Members shall include obstetrics and gynecology services (including OB Hospitalists) in the Hospital.
- T. Ophthalmology: Members shall include Ophthalmology services in the hospital.
- U. Oral/Maxillary/Facial: Members shall include Oral, Maxillary, and Facial services in the hospital, which includes General and Pediatric Dentistry.

- V. Orthopedics: Members shall include orthopedic services in the Hospital.
- W. Otolaryngology: Members shall include otolaryngology services in the Hospital.
- X. Pathology: Members shall include pathological anatomy, and clinical laboratory transfusion services in the Hospital. These services are conducted under exclusive contract.
- Y. Pediatrics: Members shall include pediatric, newborn nursery, NICU, and PICU services (including Pediatric Hospitalists) in the Hospital.
- Z. Pediatric Surgery: Members shall include Pediatric Surgery services in the hospital.
- AA. Plastic Surgery: Members shall include Plastic Surgery services provided in the hospital.
- BB. Podiatry: Members shall include Podiatric services provided in the hospital.
- CC. Psychiatry: Members shall include behavioral health services (including Psychology) in the Hospital.
- DD. Pulmonology: Members shall include Pulmonary services (including intensivists) in the Hospital.
- EE. Radiology: Members shall include medical diagnostic imaging and radiological services (including Nuclear Medicine) in the Hospital. These services are conducted under exclusive contracts.
- FF. Radiation Oncology: Members shall include radiation therapy services in the Hospital. These services are conducted under exclusive contract.
- GG. Urology: Members shall include Urology services provided in the hospital.

## **Section 8. PWFMC**

- A. Anesthesiology: Members shall include all anesthesiology services in the Hospital. These services are conducted under exclusive contract.
- B. Emergency Medicine: Members shall include all emergency medicine services in the Hospital. These services are conducted under exclusive contract.
- C. Family Medicine and Medicine: Members shall include family medicine, allergy/immunology, cardiology, dermatology, gastroenterology, hematology/oncology, infectious diseases, internal medicine, nephrology, neurology, physical medicine and rehabilitation and pulmonary disease services in the Hospital.
- D. Intensive Care Unit: Members shall include all Intensivist services in the Hospital. These services are conducted under exclusive contract.

- E. Obstetrics and Gynecology (OB/GYN): Members shall include obstetrics and gynecology services in the Hospital.
- F. Pediatrics: Members shall include all pediatric services in the Hospital.
- G. Psychiatry: Members shall include all behavioral health services providers in the Hospital.
- H. Radiology: Members shall include medical diagnostic imaging, radiation oncology, and radiological services in the Hospital. These services are conducted under exclusive contracts.
- I. Surgery: Members shall include cardiovascular / thoracic, general / vascular, neurological, ophthalmology, oral, orthopedic, otolaryngology, plastic, podiatry, surgical oncology, pathology, and urology services in the Hospital.

## **Article XIII. COMMITTEES**

### **Section 1. Oregon Medical Executive Committee**

As provided in the Bylaws, Article XI, Section 1.

### **Section 2. Medical Executive Committee**

As provided in the Bylaws, Article XI, Section 3, including authorization of disbursement of funds.

In addition:

- A. **PHRMH MEC**: The Medical Executive Committee shall consist of the President, President - Elect, Immediate Past President, the Secretary/Treasurer as described in Article XI of the Bylaws, the PQRC Chair, and four Members-at-large. The President shall attempt to establish a multidisciplinary committee; this can be accomplished by appointing the chair of various committees or a member from the various committees.

The President, President-elect, immediate past President, Secretary/Treasurer, and Members-at-large in the Active Category shall each serve a two-year term.

The President-Elect, Members-at-large, and Secretary/Treasurer shall be selected by the Nominating Committee as described in Article XV (Elections).

- B. **PMMC MEC**: shall consist of Immediate Past President, and the chairs of the Emergency Medicine, Medicine, Women's and Children's, and Surgery Departments. The Chief Executive, the Medical Staff director, the hospital nurse executive, and the Anesthesia Medical Director shall be ex officio members without vote. The Chief Executive may designate an alternate to attend any meeting to represent the hospital Chief Executive.

The President, President-Elect, Immediate Past President, Secretary-Treasurer and three Members-at-large shall each serve a two-year term.

The President-Elect, Secretary-Treasurer and Members-at-Large shall be selected by the Nominating Committee as described in Article XV (Elections).

- C. **PMH MEC:** shall consist of immediate past president, the Chairs of the Departments of Anesthesiology, Diagnostic Imaging, Emergency Medicine, Medicine, Family Medicine, Obstetrics/Pediatrics, Pathology, Psychiatry, Surgery and Director of Family Practice Residency Program. The Secretary/Treasurer shall serve a two-year term and the three Members-at-Large shall serve a one-year term and be selected by the Nominating Committee as described in Article XV. The Director of Family Medicine Residency Program shall have voting privileges at the discretion of the MEC.
- D. **PNMC MEC:** shall consist of the President, President-Elect, Secretary-Treasurer as described in Article XI of the Bylaws (Committees), Immediate Past President, up to two Members-at-Large, the Chairs of the Departments of Emergency, Medicine, Obstetrics/Pediatrics, Surgery.

The President, President-elect, Immediate Past President, Secretary/Treasurer and Members-at-large shall each serve a two-year term and be selected by the Nominating Committee as described in Article XV (Elections).

- E. **PPMC MEC:** shall consist of the Division Chiefs of Medicine and Surgery, CMO, the Director of the Department of Medical Education, the Medical Director for Quality and five members-at-large. Non-voting members will include the immediate Past-President, the PQRC chair, the hospital Chief Executive, and the Chief Nursing Officer. The Chief Executive may designate an alternate to attend any meeting to represent the hospital Chief Executive.

The Secretary/Treasurer shall serve a two-year term and be selected by the Nominating Committee as described in Article XV. The five members-at-large shall serve for three-year terms and include two members from Inpatient Specialty Medicine Division, two members from Surgery Division, and one member from Ambulatory Medicine. They shall be elected by the Active members Designated at PPMC with concurrence of the MEC. Their terms of office will expire in successive years.

- F. **PSH MEC:** shall consist of the Department Chairs. The Chief Executive may designate an alternate to attend any meeting to represent the hospital Chief Executive. The President and President-elect shall each serve a two-year term. The Secretary-Treasurer and one to three Members-at-Large shall serve a three year term.

The President-Elect, Secretary/Treasurer and Members-at-Large shall be selected by the Nominating Committee as described in Article XV (Elections).

- G. **PSVMC MEC:** Voting members shall be the, Division Chiefs of Medicine, Surgery, Women's and Children's, CMO, Isidor Brill Chair of Medical Education, and seven Members-at-Large elected by a majority of the Active Members Designated at PSVMC as described in Article XV.

The President and President-Elect shall each serve a two-year term, and the at-large members will each serve a three-year term. The terms for at-large members will run as

three concurrent cycles (i.e. a group of first-year at-large members, second year at-large members, and third year at large members). Two of the concurrent cycles will consist of 2 at-large members and one concurrent cycle will consist of 3 at-large members, for a total of seven at-large members in rotating service. Members-at-large are elected each year to fill the expiring terms. All terms of office commence on February 1<sup>st</sup>. The Chief Executive, or designee, and Past-President are non-voting members of the MEC. Department, Section or Committee Chairs may attend MEC meetings, but the MEC will adjourn to executive session for matters requiring confidentiality.

- H. **PWFMC MEC:** shall consist of the President, President-Elect, Immediate Past President, the Chairs of the Departments of Anesthesiology, Emergency, Family Medicine and Medicine, Obstetrics, Pediatrics, Radiology, Psychiatry, Surgery and Quality Medical Director. The President and President-Elect shall each serve a two-year term. The Secretary/Treasurer and four Members-at-Large shall each serve two-year terms and be selected by the Nominating Committee as described in Article XV.

### **Section 3. Oregon Credentials Committee**

As provided in the Bylaws, Article XI, Section 2.

### **Section 4. Other Committees**

As provided in the Bylaws, Article XI, Section 5.

### **Section 5. Oregon Region Institutional Review Board**

- A. Composition: The Institutional Review Board (“IRB”) shall consist of representatives from the Hospitals including Members and non-health system lay members. The Chair is appointed jointly by the OMEC and PHSOR Administration.
- B. Duties: Responsible for overseeing review and monitoring of all research studies involving human subjects at the Hospitals.

Maintain the required procedures to satisfy legal requirements, state and federal rules and regulations, the Providence Health & Services Mission and Core Values and the Roman Catholic moral tradition as articulated in such documents as The Ethical and Religious Directives for Catholic Health Care Services.

Implement PHSOR policies and procedures, and rules and regulations for safeguarding the welfare and rights of all subjects taking part in research studies that are approved by the IRB.

- C. Meetings: The Committee shall meet once a month, or as often as necessary to conduct business, shall maintain a record of proceedings, and shall forward its reports to the MEC.
- D. Reciprocity and Cooperative Agreements: The IRB shall ensure compliance when research involves multi-institutional studies with federal rules and regulations concerning research for each of the cooperating institutions. Institutions may use joint review agreement, reliance upon the review of another qualified IRB, or other similar arrangement aimed at avoidance of duplication of effort.

## Section 6. Oregon Region Pharmacy and Therapeutics Committee

- A. Composition: Members shall consist of Practicing physicians, nursing and clinical pharmacists in various clinical specialties throughout Providence Health & Services Oregon region and its affiliated partners, as deemed necessary by the Oregon Regional P&T Committee Chair(s), are members of the Committee. The Committee shall consist of not less than fifteen (15) physicians.

The chair(s) of the Oregon Region P&T Committee will be appointed by the Oregon Region Chief Medical Officer for Providence Health & Services. Any governing body may recommend a name for membership, at any time.

The Chair(s) of the Oregon Region P&T Committee or designee(s), the Oregon Region Chief Medical Officer for Providence Health & Services, and the Chief Physician Strategy Officer appoint new members. Such changes will be reported to the Hospital Medical Executive Committees.

Designated voting Committee members include: the Committee Chair (s), practicing Providence Medical Group and affiliated physician representatives, pharmacy representatives from various settings, and a clinical nurse specialist. Non-voting members may include specialty physician advisors, clinical, administrative, technical, and analytical staff to advise and assist with Committee decisions and actions.

- B. Duties: The Oregon Regional Pharmacy and Therapeutics Committee (“P&T Committee”) is responsible for providing safe, high quality, and cost effective drug therapy for Providence patients through utilization of drug evaluation activities for all Oregon ministries and departments. The P&T Committee’s functions are as follows:
1. The P&T Committee and its providers delegate authority for formulary decision-making to the centralized Providence Health and Services (PH&S) formulary process, led by a representative PH&S formulary committee of experts in medicine, pharmacy, and nursing throughout the system and continuum of care, that ensures patients of Providence and its affiliates are provided with safe, high-quality, and affordable medications throughout the continuum of care
  2. The P&T Committee accepts and adheres to the outcomes of the centralized PH&S formulary process.
  3. Identify and develop drug therapy and medication management initiatives, utilization programs and guidelines for all ambulatory, acute care and other settings in the Oregon region.
  4. The P&T Committee meetings will include and document decisions of the PH&S formulary committee.
  5. The P&T Committee, or an individual provider in coordination with a P&T lead pharmacist, may petition a PH&S formulary decision through the centralized PH&S formulary appeal process with the understanding the burden of proof of value (safety, efficacy, cost) is on those who advocate the alternative.

6. Identify and develop drug therapy and medication management initiatives, utilization programs and guidelines for all ambulatory, acute care and other settings in the Oregon region.
  7. Oversee development of communication and educational tools to communicate PH&S formulary and drug therapy decisions for multiple audiences and entities.
  8. Review and approve clinically appropriate protocols and procedures for the timely and non-discriminatory use of and access to medically necessary drugs: both formulary and non-formulary drug products; Oversee development of communication and educational tools to communicate PH&S formulary and drug therapy decisions for multiple audiences and entities.
  9. Review and approve procedures for medical review of non-formulary drug requests;
  10. Review FDA alerts, drug shortages, medication recalls, medication withdrawals, and black box warnings. Develop and approve practice protocols to address issues that require immediate actions;
  11. Oversee Drug Utilization Evaluation (“DUE”) and Medication Utilization Evaluation (“MUE”) activities.
- C. Meetings: The Oregon Region P&T Committee will meet every other month, six (6) times annually, or as necessary to complete responsibilities of the Committee. The Committee shall maintain a record of its proceedings and activities through Committee minutes. A majority of the physician Committee membership constitutes a quorum for the transaction of business. Agreement is reached by a majority vote of all attending voting members with a physician quorum. Removal of membership will be reported to the MEC and the OMEC. The Regional P&T Committee reports to the OMEC through minutes; and subsequent approval and the minutes are forwarded to the MECs for review. Direct in person reporting by the Regional P&T Committee chair(s) or designee is available upon request.
- D. Subcommittees: The work of the Committee will be supported by sub-committees, specialty advisors, and ad-hoc work groups as needed. Sub-committees, specialty advisors, and ad-hoc work groups will not have voting authority.
- E. Conflict of Interest: The Oregon Region P&T Committee, its sub-committees, and advisors will adopt Providence Health & Services (PH&S) Confidentiality (PROV-ICP-716) and Conflict of Interest Policy (PROV-GOV-208)

## **Section 7. Oregon Region Graduate Medical Education Committee (GMEC)**

- A. Composition: Voting membership is composed of the Designated Institutional Official (DIO) program directors, a minimum of two peer selected residents, and a quality improvement/safety officer or his/her designee. Additional GMEC membership may include others as determined by the GMEC. Each meeting of the GMEC must include attendance by at least one resident member.
- B. Duties:
1. Oversight of:
    - a. The ACGME accreditation status of the Sponsoring Institution and its ACGME-accredited programs

- b. The quality of the GME learning and working environment within the Sponsoring Institution, its ACGME-accredited programs, and its participating sites
  - c. The quality of educational experiences in each ACGME-accredited program that lead to measureable achievement of educational outcomes as identified in the ACGME Common and specialty-specific Program Requirements
  - d. All processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution
2. Review and approval of:
- a. Institutional GME policies and procedures
  - b. Annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits
  - c. Applications for ACGME accreditation of new programs
  - d. Requests for permanent changes in resident complement
  - e. Major changes in ACGME-accredited programs' structure or duration of education
  - f. Additions and deletions of ACGME-accredited programs' participating sites
  - g. Appointment of new program directors
  - h. Progress reports requested by a Review Committee
  - i. Responses to Clinical Learning Environment Review reports
  - j. Request for exceptions to duty hours requirements
  - k. Voluntary withdrawal of ACGME program accreditation
  - l. Requests for appeal of an adverse action by a Review Committee
  - m. Appeal presentations to an ACGME appeals panel
3. The GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR)
- a. The GMEC must identify institutional performance indicators for the AIR which include:
    - i. Results of the most recent institutional self-study visit
    - ii. Results of ACGME surveys of residents and core faculty
    - iii. Notification of ACGME-accredited programs' accreditation statuses and self-study visit
  - b. The AIR must include monitoring procedures for action plans resulting from the review
  - c. The DIO must submit a written annual executive summary of the AIR to the Governing Body
4. The GMEC must demonstrate effective oversight of underperforming programs through a Special Review Process.
- a. The Special Review Process must include a protocol that:
    - i. Establishes criteria for identifying underperformance; and
    - ii. Results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.

- C. Meetings: The Committee shall meet at least quarterly with agendas distributed in advance. Minutes are distributed to members, posted to the GME Sharepoint site, and maintained in the GME office. Committee shall forward its minutes and reports to the MECs through the Residency Program Directors, who are voting members of the MECs. An annual report shall be presented to the OMEC by the GMEC Chair.
- D. Subcommittees: The work of the GMEC may be supported by subcommittees as needed. Subcommittees that address required GMEC responsibilities must include a peer-selected resident/fellow. Subcommittee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC.

## **Section 8. Oregon Region Obstetric/Newborn Quality Committee**

- A. Composition: Membership The committee shall consist of active Members of the Professional Staff who are representative of obstetric (includes Obstetrics/Gynecology, Family Medicine and Nurse Midwifery practitioners with obstetric privileges, Anesthesia representation (MD/DO, and CRNA) and pediatric (includes Family Medicine, Pediatric practitioners and Neonatal Nurse Practitioners with newborn privileges) groups that practice in the Hospitals and one representative from each Hospital perinatal nursing unit. Obstetric and Pediatric Department chairs, PSVMC Women and Children’s Division Chief, and/or Medical Directors, and Women and Children’s Program Oregon Region Medical Director, shall be Ex Officio members with voting privileges. Representation shall be as follows: for each practice group with a membership of 8 or greater providers, the group may appoint two representatives; for practices of 4-8 providers, the group may appoint one representative; two providers will be appointed to represent small group providers in their specialty. Other members representing the hospital departments/perinatal nursing units shall be members without vote. The Women and Children’s Program Oregon Region Medical Director shall chair the committee. Individuals may be invited to act as consultants on specific issues.
- B. Duties: The Oregon Region Obstetric/Newborn Quality Committee is responsible for the following:
  - 1. Clinical Performance Measurement: Selection of meaningful performance measures; collection and analysis of performance data; communicate performance information to department chairs and practice group representatives; identify and act on opportunities for improvement. Assure quality and provide oversight and coordination of perinatal and newborn care services.
  - 2. Oregon Region Policies: Develop and approve professional practice policies affecting the provision of care in each setting;
  - 3. Standards Development: Ensure appropriateness of care to perinatal and newborn patients by developing evidenced based standardized order sets and protocols; develop and implement risk models for clinical decision making.
  - 4. Privileging: Provide expert opinion and input to the Oregon Region Credentials Committee regarding experience and qualifications necessary for privileging.

5. Provide guidance to Professional Staff Obstetric and Pediatric Departments in the implementation of approved policies and standards of practice.
  6. Advocate for resources that enhance education for all Members and clinical staff Hospital employees.
  7. Quality Priorities/Prioritization: Establish annual goals and objectives. As projects are brought forward committee will prioritize goals given resource availability.
- C. Meetings: The Oregon Region Obstetric/Newborn Quality Committee shall meet at least four times per year and maintain a record of the proceedings and activities with agendas and meeting packets distributed in advance. Agendas will indicate items for discussion, recommendation or decision. Minutes are distributed to members and maintained for review. Committee shall forward its reports to Hospital Professional Staff Obstetric and Pediatric Departments for information, input and feedback, and to the Oregon Medical Executive Committee.
- D. Subcommittees: Working subcommittees of the whole will be chaired by a physician member of the committee and will submit minutes, reports, and recommendations to the Oregon Region Obstetric/ Newborn Quality Committee for final recommendation and approval.

## **Section 9. Oregon Region Children's Services Quality Committee**

- A. Composition Members shall consist of active Professional Staff Members and one administrative member who are representative of pediatric activities from each of the Oregon Region Providence hospitals. In addition membership shall consist of the PSVMC Women and Children's Division Chief, the PSVMC Pediatric Surgery Medical Director, either the PPMC or PSVMC Neonatal Intensive Care Medical Director, the PSVMC Acute Services Medical Director, the PSVMC Pediatric Intensive Care Medical Director, the Child Psychiatry Medical Director, the Oregon Region Pediatric Anesthesia Medical Director, the Oregon Region Emergency Room Medical Director, the PSVMC Pediatric ED Medical Director, representatives from Oregon Region Pharmacy, Lab, and Diagnostic Imaging, and the Women and Children's Program Oregon Region Children's Services Medical Director.
- B. Duties: The Oregon Region Children's Quality Committee is responsible for the following:
1. Clinical Performance Measurement: Selection of meaningful performance measures; collection and analysis of performance data; communicate performance information to department chairs and practice group representatives; identify and act on opportunities for improvement.
  2. Oregon Region Policies: Develop and approve professional practice policies affecting the provision of care for children in each setting;

3. **Standards Development:** Ensure appropriateness of care to children by developing evidenced based standardized order sets and protocols and review of system EPIC order sets.
  4. **Privileging:** Provide expert opinion and input to the Oregon Region Credentials Committee regarding experience and qualifications necessary for privileging.
  5. Provide guidance to all Oregon Region hospitals in the implementation of approved policies and standards of practice as it relates to children.
  6. Advocate for resources that enhance education for all Members and clinical staff.
  7. **Quality Priorities/Prioritization:** Establish annual goals and objectives. As projects are brought forward, the committee will prioritize goals given resource availability.
- C. **Meetings:** The Oregon Region Children’s Services Quality Committee shall meet at least four times per year and maintain a record of the proceedings and activities with agendas and meeting packets distributed in advance. Agendas will indicate items for discussion, recommendation or decision. Minutes are distributed to members and maintained for review. Committee shall forward its reports to Hospital Professional Staff Obstetric and Pediatric Departments, Hospital Medical Executive Committees, the Oregon Region Women and Children’s Program, and to the Oregon Medical Executive Committee for information, input and feedback.
- D. **Subcommittees:** Working subcommittees of the whole will be chaired by a physician member of the committee and will submit minutes, reports, and recommendations to the Oregon Region Children’s Services Quality Committee for final recommendation and approval.

## **Section 10. Oregon Infectious Diseases Council (IDC)**

- A. **Composition:** Membership of the IDC will include a minimum of three physicians, pharmacists, infection preventionists, laboratory leadership, and Employee Health personnel.
- B. **Duties:** The IDC is responsible for the following:
1. Ensures optimal care in the prevention, diagnosis, and treatment of Infectious Diseases.
  2. Works collaboratively with Administrative and Physician Leadership on matters relating to Infectious Diseases.
  3. Generates objectives and action plans
- C. **Meetings:** General IDC meetings will occur bimonthly. For all meetings a quorum will be a simple majority of the membership currently serving. Issues or processes that require approval will be voted upon by the members in a voice vote unless otherwise requested. A majority vote will be required for approval of the members present at the time of voting.

1. Four task forces are subcommittees of the IDC who focus efforts ensures maximal utilization of the skills of the professional participants. The task forces include:
  - a. Antibiotic Stewardship (to include deliberation of the Pharmacy and Therapeutics Committee)
  - b. Infection Prevention and Employee Health
  - c. Clinical Microbiology and Molecular Diagnostics for Infectious Diseases
  - d. Infectious Diseases Telemedicine and Outreach
2. Duties: The IDC Task Forces are responsible for the following:
  - a. Each task force will establish and prioritize short- and long-term objectives. The latter will be vetted by the entire IDC.
  - b. Each task force will generate action plans that include deadlines for implementation and accountability.
3. Meetings: Task forces will meet on a schedule determined by the chairs. The IDC shall forward its reports to the Medical Executive Committees of Hospitals, and Oregon Medical Executive Committee.

#### **Section 11. Oregon Region Blood Utilization Committee**

- A. Composition: Membership shall consist of a Chair who is the current Regional Director, Blood Bank, Active Members that represent the PHSOR in Pathology and Hematology, with Anesthesiology, Cardiothoracic Surgery, Intensivists and Hospitalists included on an ad hoc basis. Non-physician representation from Blood Bank, Nursing, Perfusion, Pharmacy, Quality Management and Administration will be determined by the committee. Other Members and Hospital staff committee members will be appointed by the Chair.
- B. Duties: The Oregon Region Blood Utilization Committee is responsible for the following:
  1. Develop a uniform approach to monitoring and providing oversight for blood use.
  2. Establish systems to generate physician specific blood utilization reports.
  3. Implementation of ongoing proactive assessment and performance improvement in blood ordering and appropriate usage.
  4. Ensure that policies and procedures for transfusion therapy conform with regulatory and accrediting standards.
  5. Provide meaningful and relevant feedback to clinical departments, committees, and executive leaders.
- C. Meetings: The Oregon Region Blood Utilization Committee shall meet as often as necessary to conduct its business, shall maintain a record of its proceedings and activities, and shall forward its reports to the MEC. An annual report shall be presented to the OMEC.

#### **Section 12. Oregon Region Cardiac & Vascular Quality Committee**

- A. Composition: Membership shall consist of active Members of the Professional Staff who are representative of Cardiology (includes Electrophysiology), Interventional

Radiology, Vascular and Cardiac Surgery groups; additional specialties will be added as relevant to the care of heart and vascular patients; representatives from hospital cardiac nursing units; quality management representatives; and Heart and Vascular Program staff. The Heart and Vascular Program Quality Regional Medical Directors shall chair the committee. Individuals may be invited to act as consultants on specific issues.

B. Duties: The Regional Cardiac & Vascular Quality Committee is responsible for the following:

1. Clinical Performance Measurement: Selection of meaningful performance measures; collection and analysis of performance data; communicate performance information to individual providers; identify and act on opportunities for improvement.
2. Standards Development: Ensure appropriateness of care to cardiothoracic and vascular patients by developing evidenced based standardized order sets and protocols; develop and implement risk models for clinical decision making.
3. Clinical Data Management: Measure clinical effectiveness of identified procedures through definition of data elements, establish data bases, and provide expert statistical analysis and reporting, approval of specific data requests by individuals and groups.
4. Privileging: Provide expert opinion and input to the Oregon Credentials Committee regarding experience and qualifications necessary for privileging.
5. Dashboard: Committee will conduct a quarterly review of a clinical quality dashboard, analyze trends and make recommendations for any further follow up.
6. Quality Projects prioritization: As projects are brought forward committee will prioritize given established goals resource availability.
7. Quality Priorities: Establish annual goals and objectives. Identify needed resources and act as advocate.

C. Meetings: The Regional Cardiac & Vascular Quality Committee shall meet monthly or on an as needed basis. Committee shall forward its reports to the Medical Executive Committee, Oregon Medical Executive Committee, PHVI Executive Leadership Council, and Community Ministry Board.

D. Subcommittees: Some issues will be referred to subcommittees. Working subcommittees of the whole will be chaired by a physician member of the committee and will submit minutes, reports and recommendations to the Cardiovascular Quality Committee for final recommendation and approval.

### **Section 13. Infection Control Committee - PMH, PPMC, PSVMC, PWFMC**

- A. Composition: The Infection Control Committee shall consist of Members, representatives from administration, nursing, infection control, pharmacy and other departments deemed appropriate. The Chair will be appointed by the MEC Chair.
- B. Duties: The Infection Control Committee, in conjunction with the Hospital epidemiologist, shall be responsible for the following:
  - 1. infection surveillance for patients and employees;
  - 2. monitoring of antimicrobial usage;
  - 3. promotion of a preventative and control program designed to minimize infection hazards, including development of infection control and immunization policies; and
  - 4. oversight of infection control aspects of the Hospital's activities.
- C. Meetings: The Infection Control Committee shall meet as often as necessary to conduct its business, shall maintain a record of its proceedings and activities, and shall forward its reports to the MEC.

**Section 14. Quality Councils – PHRMH, PMH, PMMC PPMC, PSH, PSVMC, PWFMC**

A. Composition

PHRMH Quality Council: shall consist of members and representatives of the Professional Staff, Management Staff, and Quality Improvement Personnel.

PMH, PMMC, PPMC, PSH, PSVMC and PWFMC Quality Councils: shall consist of Members and representatives of administration, nursing, finance, and other departments deemed appropriate. The Chair or Co-Chairs will be appointed jointly by the Chief Executive and President. Other Members and Hospital staff committee members will be appointed by the Chair (Co-Chairs). Standing positions on the Quality Council shall include, but not be limited to, Members as designated by the President, the Chief Executive or designee, the Chief Executive of Patient Care Services, the Director of Finance, the Regional Director for Quality and Medical Management, and the Director of Quality Management and Medical Staff Services.

PNMC Quality Council: shall consist of members and representatives of the Medical Staff, Management Staff, Performance Improvement/Medical Staff Services Personnel, and Human Resource Director.

B. Duties: The Quality Council is responsible for the following:

- 1. translating the priorities of the Quality Committee of the Board into a quality vision for each Hospital;
- 2. setting Hospital-specific priorities;
- 3. designing and overseeing the Quality Plan;
- 4. commissioning and providing oversight for quality improvement teams; and
- 5. promoting organizational education and training in quality improvement.

C. Meetings: The Quality Council shall meet as often as necessary to conduct its business, keep a record of its proceedings and forward its reports to the MEC.

## **Section 15. Quality Improvement Committee (QIC) - PPMC**

- A. Composition The QIC shall consist of representatives of administration, nursing, finance, and other departments deemed appropriate. The chief Executive Officer of PPMC serves and appoints the members.. Standing positions on the Quality Improvement Committee shall include, but not be limited to, , Chief Nursing Officer, the Chief Operating Office, the Chief Financial Officer and the Director for Quality Resources.
- B. Duties: The Quality Improvement Committee is responsible for the following:
1. Translating the priorities of the Quality Committee of the Board into a quality vision for each Hospital;
  2. Setting Hospital-specific priorities;
  3. Designing and overseeing the Quality Plan;
  4. Commissioning and providing oversight for quality improvement teams; and
  5. Promoting organizational education and training in quality improvement.
- C. Meetings: The Quality Council shall meet as often as necessary to conduct its business, keep a record of its proceedings and forward its reports to the MEC.

## **Section 16. Radiation Safety Committee - PMH, PPMC & PWFMC, PSVMC**

- A. Composition: The Radiation Safety Committee shall be composed of three or more Members, including representatives of the Department of Oncology, the Department of Pathology and the Department of Radiology, as well as the Hospital radiation physicist.
- B. Duties: The Radiation Safety Committee shall be responsible for establishing and implementing policies for the safe and effective use of radiotherapy equipment and radioactive materials.
- C. Meetings: The Radiation Safety Committee shall meet as often as necessary, shall maintain a record of its proceedings and activities, and shall forward its reports to the MEC.

## **Section 17. Cancer Committees**

- A. Regional Cancer Committee (comprising of PMH, PPMC, PSVMC, PWFMC)
1. Composition: This Regional Cancer Committee is a joint multidisciplinary committee of the Hospital and Professional Staff and shall be composed of, but not limited to, the following: representatives of the Professional staff who have special interest and expertise in cancer including those from the diagnostic and treatment specialties. Specifically to be included are representatives from surgery, medical oncology, diagnostic radiology, radiation oncology, pathology, and palliative care. The Regional Cancer Committee Chair shall be a physician who may fill one of the other required physician roles. It should also include representatives from nursing, social work, pharmacy, the tumor registry, nutrition services, hospice, administration and quality management.

2. Duties: The Regional Cancer Committee, in accordance with criteria established by the Commission on Cancer of the American College of Surgeons, performs the following roles:
  - a. Develops and evaluates the annual goals and objectives for the endeavors related to cancer care;
  - b. Monitors and evaluates cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation;
  - c. Establishes and implements a plan to evaluate the quality of cancer registry data;
  - d. Analyzes patient outcomes and disseminates the results;
  - e. Develops a process to monitor physician use of staging , prognostic indicators, and evidence based guidelines in treatment planning;
  - f. Ensures that pathology reports contain the elements identified by the College of American Pathologists;
  - g. Monitors community outreach activities;
  - h. Ensures that cancer-related educational activities are offered to physicians, nurses, and allied health staff;
  - i. Completes and documents studies that measure quality and outcomes;
  - j. Implements improvements that directly affect cancer patient care.
3. Meetings: This committee shall meet at least quarterly, shall maintain a record of its proceedings and activities, and shall forward its reports to the MEC.

#### B. Cancer Committee – PMMC

1. Composition - Required members include at least one physician representing each of the diagnostic and treatment services. The Cancer Committee includes at least one (1) physician member from these specialties: diagnostic radiology, pathology, general surgery, medical oncology, and radiation oncology. The committee shall consist of at least one (1) member from: Cancer program administration, oncology nursing, social services, a Certified Tumor Registrar, and quality improvement. A pain control specialist or palliative care physician is a required member of the committee. The cancer committee chair is a physician who may also fulfill the role of one of the required physician specialties. The Cancer Liaison Physician must be a member of the cancer committee and may fulfill the role of one o the required physician specialties. Additional members may include but are not limited to: dietary/nutrition specialist, pharmacist, pastoral care representative, psychiatric or behavioral health professional, American Cancer Society Cancer Control representative, or a public member of the community served if requested by the Committee.
2. Duties: The PPMC Cancer Committee, in accordance with criteria established by the Commission on Cancer of the American College of Surgeons, performs the following roles:
  - a. Develops and evaluates the annual goals and objectives for the endeavors related to cancer care;
  - b. Monitors and evaluates cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation;

- c. Establishes and implements a plan to evaluate the quality of cancer registry data;
  - d. Analyzes patient outcomes and disseminates the results;
  - e. Develops a process to monitor physician use of staging , prognostic indicators, and evidence based guidelines in treatment planning;
  - f. Ensures that pathology reports contain the elements identified by the College of American Pathologists;
  - g. Monitors community outreach activities;
  - h. Ensures that cancer-related educational activities are offered to physicians, nurses, and allied health staff;
  - i. Completes and documents studies that measure quality and outcomes;
  - j. Implements improvements that directly affect cancer patient care.
3. Meetings - meets at least quarterly.

## **Section 18. Special Care Committees**

### **A. Intensive Care Unit - PMH:**

- 1. **Composition:** The Critical Care Committee shall consist of the Chair, five other Members, an Anesthesiologist, Emergency Medicine physician, Critical Care Coordinator, Nursing Director representative, and Respiratory Therapy representative.
- 2. **Duties:** It shall review and advise the MEC, through the Department of Medicine, regarding policies and standards of medical care rendered within the Critical Care Unit.
- 3. **Meetings:** The Committee shall meet as often as necessary to conduct its business, shall maintain a record of its proceedings and shall forward its reports to the MEC.

### **B. Critical Care Multidisciplinary Committee - PPMC**

- 1. **Composition:** The Critical Care Multidisciplinary Committee shall consist of the following: Chairman appointed by the President, nursing representatives from the CICU and ICU, and Administration; Members representing cardiovascular surgery, cardiology, general surgery, medicine, family medicine and anesthesiology; Director of Respiratory Care Services or his/her designee, and multidisciplinary members appointed by the Chair who are involved in the care of patients in the Critical Care Units (Pharmacy, Nutrition, Metabolic Support Team, Quality Management).
- 2. **Duties:** The Critical Care Multidisciplinary Committee is responsible for:
  - a. formulating and periodically reviewing operational policies, protocols for treatment modalities and other rules governing conduct and procedures in the CICU;
  - b. development of screening criteria, to review the quality and appropriateness of care provided in the unit, review findings, and make recommendations for corrective action and/or education programs, as indicated;

- c. recommendations related to equipment, drugs, supplies and other items to be available in the unit.
3. Meetings: The Critical Care Multidisciplinary Committee shall meet as often as necessary to conduct its business, shall maintain a record of its proceedings and activities, and shall forward its reports to the MEC.

C. Critical Care Committee –PWFMC:

1. Composition: The Critical Care Committee shall consist of the Chair, five other Members, an Anesthesiologist, Emergency Medicine physician, Critical Care Coordinator, Hospitalist, Infection Control, Nursing Director representative, and Respiratory Therapy representative.
2. Duties: It shall review and advise the MEC regarding policies and standards of medical care rendered within the Critical Care Unit.
3. Meetings: The Committee shall meet as often as necessary to conduct its business, shall maintain a record of its proceedings and shall forward its reports to the MEC.

**Section 19. Renal Service - PPMC**

- A. Composition: Membership shall consist of a Chair, Active Members in the specialty of nephrology, and one representative each from administration, nursing, social work and dietetics. A vascular surgeon may attend meetings to provide advise on surgical access or other surgical needs of renal failure patients.
- B. Duties: The Renal Services Committee shall oversee the continuous quality improvement process of the Dialysis Unit; monitor the policies and procedures of the Dialysis Unit; make recommendations for new equipment for the Dialysis Unit; and make recommendations regarding monitoring changes.
- C. Meetings: The Committee shall meet as often as necessary to conduct its business, shall maintain a record of its proceedings and activities, and shall forward its reports to the MEC.

**Article XIV. MEETINGS**

**Section 1. Notice**

A written notice and agenda items, if available, shall be provided to the Members approximately seven days prior to the meeting date.

**Section 2. Quorum**

There shall be no minimum number of Active Members of a Department or Committee to constitute a quorum at a properly called meeting unless otherwise specified.

**Section 3. Manner of Action**

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

Except as otherwise provided, the action of a majority of the Members present and eligible to vote at a meeting shall be the action of the Department or Committee. Mail or electronic balloting following a meeting may be exercised at the discretion of the Chair.

#### **Section 4. Rights of Ex Officio Members**

Except as otherwise provided in these Policies, persons serving as ex officio members of a Committee shall have all rights and privileges of regular members, except they shall not be allowed to vote.

#### **Section 5. Department/Committee Meetings**

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

#### **Section 6. General Professional Staff Meetings**

As provided in Article XII, Section 1 in the Bylaws.

### **Article XV. ELECTIONS**

#### **Section 1. Nominating Committees (PHRMH, PMH, PPMC, PNMC, PPMC, PSH, PSVMC, PWFMC)**

1. Composition: The Nominating Committee shall be composed of the President, President-Elect and at least one other Active Member who will be selected by the MEC. Five additional Active Members will be selected by the MEC for PPMC and PSVMC to serve on the Nominating Committee.
2. Duties: The Nominating Committee shall convene at least ninety (90) days prior to the expiration of an officer or other elected member's term. The Committee shall submit, to the President and/or Medical Staff Office, one or more qualified nominees for each open office/position. Members of the Nominating Committee are not barred from becoming nominees for office/position themselves. Nominees are contacted to confirm their willingness to serve in the office/position, if elected. Upon approval by the MEC, a notice with the names of the candidates for each office/position will be submitted to the Active Members at least thirty (30) days prior to the election.
3. Nominations by Petition: Nominations may also be made by petition signed by at least 20 Active Members or 25 percent of the Active Staff Members (whichever is the lesser number) and filed with the President and/or Medical Staff Office at least ten (10) days prior to the election. As soon as possible, the names of these additional candidates shall be reported to the Active Members.

4. By Other Means: If, before the election, any of candidates for an office shall refuse, be disqualified from, or otherwise be unable to accept nomination, the Nominating Committee shall submit one or more substitute nominees for the ballot.

## **Section 2. Elections**

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

## **Article XVI. MEDICAL STUDENTS, RESIDENTS, AND FELLOWS**

### **Section 1. Medical and Non-Physician Students**

Students may be allowed to participate in patient care in the Hospital with a Member with clinical privileges under the following guidelines:

- A. Must be currently enrolled in an accredited medical school or accredited professional school/training program leading to independent practice. These may include, but are not limited to training programs in medicine, podiatry, dentistry, clinical psychology, certified nurse midwifery, nurse practitioner disciplines, Physician Assistants, or advanced nursing anesthesia.
- B. Non-Providence students must have an affiliation agreement between PHSOR and their training program. Providence employed students do not require an affiliation agreement, but the training program director must provide goals and objectives, including supervision expectations, to the Member supervising the rotation. Providence employed Psychology postdoctoral interns and residents will be considered students who do not write orders.
- C. Student applications for rotations must identify the PHSOR supervising Member who has agreed to accept responsibility for teaching and formal evaluation during the rotation and specify the duration and content of the educational activity.
- D. Students must always work only under the supervision of a Member and may not be the admitting or attending practitioner.
- E. Students may perform procedures under direct supervision of a Member. Students may also assist at surgery or other procedures, but may not be the primary surgeon in procedures.
- F. Patients must be made aware of, and consent to, student involvement in their care (i.e., surgery, diagnostic procedure, making rounds, etc.).
- G. Student orders must be countersigned by the supervising Member or supervising resident prior to execution.
- H. Members may only use portions of the student note for billing purposes in accordance with CMS documentation guidelines, which must be completed within 24 hours of the date of service for inpatient notes. This duty may be delegated to a resident or fellow supervising the student if there is a separate Member note or resident/fellow note

attested by a Member on that date of service for billing purposes. Student notes require an appropriate attestation statement and co-signature.

- I. Students must wear Providence name badge at all times.
- J. Students must undergo background checks and training as specified in the affiliation agreement with the training program.
- K. PHSOR supervising Members must be in good standing with the professional staff and attest to their understanding of these requirements.

## **Section 2. Residents from Programs Sponsored by PHSOR**

- A. Residents are selected according to policies and procedures established by the PHSOR Graduate Medical Education Committee (GMEC) and PHSOR training programs. Resident supervision policies and procedures are developed by the PHSOR GMEC in accordance with the requirements of accrediting bodies, such as Accreditation Council of Graduate Medical Education, as well as the Oregon Medical Board.
- B. The PMH and PPMC Professional Staffs have delegated implementation of resident patient care activities to their Departments of Medical Education. The PSVMC administration has delegated implementation of resident patient care activities to the Departments of Medicine and Surgery. The PHRMH administration has delegated implementation of resident patient care activities to the family medicine residency director. The PHSOR Professional Staff has delegated the functions of the GMEC, in compliance with the Institutional Requirements of the Accreditation Council for Graduate Medical Education, to the PHSOR GMEC.
- C. PHSOR Residents are learners in accredited physician residency programs. Interns are residents in their first year of training and are treated the same as residents in this policy. While performing curricular elements of their training program in the Hospital, PHSOR Residents must follow PHSOR GMEC and residency program specific supervision guidelines and follow these requirements:
  - 1. Must provide documentation of successfully obtaining MD or DO degree.
  - 2. Must hold a valid, current license issued by the Oregon Medical Board.
  - 3. Must undergo other appropriate background checks, training, and verification as a learner in good standing as specified in their employment contract.
  - 4. May only work under the supervision of a Member with clinical privileges in accordance with accreditation guidelines.
  - 5. May perform procedures or portions of procedures under the supervision and with the permission of a Member. The supervision may be direct supervision, indirect supervision, or oversight in accordance with the supervision guidelines of the training program and the learner's prior procedural experience.
  - 6. May assist at surgery, but may not be the primary surgeon in procedures requiring anesthesia services.
  - 7. May participate in call coverage with a supervising Member in accordance with accreditation requirements, but may not be the primary provider responsible for call duties.
  - 8. May not be the attending practitioner of record.

9. May perform and record the History and Physical, progress notes, and discharge summaries. The Member must personally write an appropriate attestation statement as part of the resident's note. The attestation statement must be written in accordance with applicable CMS supervision documentation regulations and inpatient documentation must be attested within 24 hours of the date of service.
  10. May write patient care orders without requirement for co-signature.
  11. Must make patients aware of, and consent to, resident involvement in their care.
  12. Must wear Providence name badge at all times.
- D. PHSOR Residents may not become privileged members of the professional staff. Chief residents in internal medicine are graduates of an accredited internal medicine residency training program and are therefore eligible for privileging.
- E. PHSOR supervising Members must be in good standing and must attest to their understanding of responsibilities outlined in these policies and procedures.
- F. Members overseeing residents by indirect supervision are responsible for reviewing labs, radiologic studies, electrocardiograms, fetal heart tracings and other data that residents use when presenting patients within 24 hours, typically when the inpatient note is attested. In situations where the supervising Member feels there is a substantive risk of patient harm from misinterpretation of a critical diagnostic test, the Member must review the test concurrently via remote technology or provide direct confirmation of the critical test at the bedside.

### **Section 3. Residents From Programs Not Sponsored by PHSOR**

Residents, from accredited residencies in medicine, podiatry, and oral-maxillofacial surgery or other health professional training programs not sponsored by PHSOR may participate in patient care in the Hospital with a supervising Member with clinical privileges. Interns are residents in their first year of training and treated the same as residents under these policies and procedures.

- A. Non-PHSOR Residents must fulfill the following requirements:
1. Must provide documentation of successfully obtaining MD, DO, DPM, DDS/DMD degree, or other degree deemed acceptable by the Providence Regional GME Office appropriate to their training background.
  2. Must hold a valid, current license in their area of training issued by the State of Oregon, such as the Oregon Medical Board or Dental Board.
  3. Must undergo other appropriate background checks, training, and verification as a learner in good standing as specified in the affiliation agreement with the training program.
  4. May only work under the supervision of a Member with clinical privileges in accordance with accreditation guidelines and training program requirements.
  5. May perform and record the History and Physical, progress notes, and discharge summaries. The Member must personally write an appropriate attestation statement as part of the resident's note. The attestation statement must be written in accordance

with applicable CMS supervision documentation regulations and inpatient documentation must be attested within 24 hours of the date of service.

6. May write patient care orders without requirement for co-signature.
  7. May perform procedures or portions of procedures under the supervision and with the permission of a Member. The supervision may be direct supervision, indirect supervision or oversight in accordance with the supervision guidelines of the training program and the learner's prior procedural experience.
  8. May assist at surgery, but may not be the primary surgeon in procedures requiring anesthesia services.
  9. May participate in call coverage with a supervising Member in accordance with accreditation requirements, but may not be the primary provider responsible for call duties.
  10. May not be the attending practitioner of record.
  11. Must make patients aware of, and consent to, resident involvement in their care.
  12. Must wear Providence name badge at all times.
- B. Non-PHSOR Residents may not become privileged members of the professional staff.
- C. Prior to being enrolled in a training rotation, non-PHSOR residents must ensure an affiliation agreement between PHSOR and their training program exists. They must also ensure a program letter of agreement (for ACGME programs) or other documentation (for non-ACGME programs) is provided if not specified in the affiliation agreement which:
1. Identifies the PHSOR clinical faculty accepting responsibility for teaching, supervision, and formal evaluation.
  2. Specifies the duration and content of the educational experience
  3. Provides the policies and procedures from the training program that will govern resident education during the assignment to PHSOR, particularly resident supervision
- D. PHSOR supervising Members must be in good standing and must attest to their understanding of responsibilities outlined in these policies and procedures.
- E. Members overseeing residents by indirect supervision are responsible for reviewing labs, radiologic studies, electrocardiograms, fetal heart tracings and other data that residents use when presenting patients within 24 hours, typically when the inpatient note is attested. In situations where the supervising Member feels there is a substantive risk of patient harm from misinterpretation of a critical diagnostic test, the Member must review the test concurrently via remote technology or provide direct confirmation of the critical test at the bedside.

#### **Section 4. Non-Privileged Fellows**

- A. Fellows from fellowships accredited by the ACGME may participate in patient care in the Hospital with a supervising Member with clinical privileges. This section also applies to fellows enrolled in a non-ACGME training program who are not privileged.
- B. Non-privileged Fellows must fulfill the following requirements:

1. Must provide documentation of successfully obtaining MD, DO or DDS/DMD degree.
  2. Must hold a valid, current license issued by the Oregon Medical or Dental Board.
  3. Must undergo other appropriate background checks, training, and verification as a learner in good standing as specified in the affiliation agreement with the training program if a non PHSOR employed or as specified in the employment contract if PHSOR employed.
  4. May only work under the supervision of a Member with clinical privileges in accordance with accreditation guidelines and training program requirements.
  5. May perform procedures or portions of procedures under the supervision and with the permission of a Member. The supervision may be direct supervision, indirect supervision or oversight in accordance with the supervision guidelines of the training program and the learner's prior procedural experience.
  6. May assist at surgery, but may not be the primary surgeon in procedures requiring anesthesia services.
  7. May participate in call coverage with a supervising Member in accordance with accreditation requirements, but may not be the primary provider responsible for call duties.
  8. May not be the attending practitioner of record.
  9. May perform and record the History and Physical, progress notes, and discharge summaries. The Member must personally write an appropriate attestation statement as part of the fellow's note. The attestation statement must be written in accordance with applicable CMS supervision documentation regulations and inpatient documentation must be attested within 24 hours of the date of service.
  10. May write patient care orders without requirement for co-signature.
  11. Must make patients aware of, and consent to, fellow involvement in their care.
  12. Must wear Providence name badge at all times.
- C. Prior to being enrolled in a training rotation, non-PHSOR fellows must ensure an affiliation agreement between PHSOR and their training program exists. They must also ensure a program letter of agreement (for ACGME programs) or other documentation (for non-ACGME programs) is provided in addition to the affiliation agreement which:
1. Identifies the PHSOR clinical faculty accepting responsibility for teaching, supervision, and formal evaluation.
  2. Specifies the duration and content of the educational experience
  3. Provides the policies and procedures from the training program that will govern fellow education during the assignment to PHSOR, particularly fellow supervision
- D. PHSOR supervising Members must be in good standing and must attest to their understanding of responsibilities outlined in these policies and procedures.
- E. Members overseeing residents by indirect supervision are responsible for reviewing labs, radiologic studies, electrocardiograms, fetal heart tracings and other data that residents use when presenting patients within 24 hours, typically when the inpatient note is attested. In situations where the supervising Member feels there is a substantive risk of patient harm from misinterpretation of a critical diagnostic test, the

Member must review the test concurrently via remote technology or provide direct confirmation of the critical test at the bedside.

## **Section 5. Privileged Fellows from non-ACGME Programs**

- A. Fellows from training programs not under ACGME jurisdiction are advanced learners in highly specialized disciplines where additional subspecialty certification is often not available. They are already board certified/board eligible in a core discipline. They are gaining focused clinical experience under the mentorship and supervision of another, more experienced privileged member of the professional staff.
- B. Privileged fellows must meet all criteria outlined elsewhere in this document for regular professional staff membership. They may only independently exercise those procedures they have been privileged for and operate under supervision for those advanced procedures they are in training for according to the requirements of their training program.
- C. Privileged fellows may or may not be employed by PHSOR. Non-PHSOR fellows require an affiliation agreement between PHSOR and their training program. Supplemental documentation must also be provided which:
  - 1. Identifies the PHSOR clinical faculty accepting responsibility for teaching, supervision, and formal evaluation.
  - 2. Specifies the duration and content of the educational experience
  - 3. Provides the policies and procedures from the training program that will govern fellow education during the assignment to PHSOR, particularly fellow supervision
- D. Privileged fellows must wear a Providence name badge at all times and make patients aware of their role in a formal training program when conducting procedures that are not a routine part of their regular clinical privileges.

## **Section 6. Medical Observers**

- A. Medical Observers are typically individuals preparing for careers in medicine, podiatry, dentistry, clinical psychology, physician assistant, certified nurse midwifery, nurse practitioner disciplines, or advanced nursing anesthesia but not yet enrolled in a formal education program
- B. Medical Observers may also be medical students, residents, fellows, or fully licensed physicians present to observe aspects of patient care for educational purposes when a full affiliation agreement or privileging and involvement in direct patient care is not required to meet educational goals.
- C. Medical Observers who wish to observe less than eight hours must comply with the PHSOR Onsite Career Exploration Policy.
- D. Medical Observers who wish to observe over eight hours must fulfill the following requirements:
  - 1. Must undergo appropriate background checks, health screening, and training in hospital policies in accordance with current Providence human resources process.
  - 2. Must be accompanied by the Medical Staff member at all times when observing patient care

3. Must not interact with patients independently
  4. Must make patients aware of, and consent to, observation of their care
  5. May not have access to the medical record, make chart entries, or write orders
  6. May not provide medical care including performing patient interviews and histories, examining patients, providing medical advice to a patient, or assisting in procedures.
  7. May not use the observership experience towards meeting the requirement of a formal degree program.
  8. May participate in discussions of patient interactions and clinical findings with their supervisor and attend educational events.
  9. Must wear a Providence name badge at all times with their status clearly marked.
- E. It is an individual Hospital's prerogative to allow observers for more than eight hour increments. In Hospitals that elect to host observers, the Hospital leadership will allocate administrative assets other than the GME or medical staff office to interact with the observer, ensure on-boarding materials are completed, and obtain a security badge.
- F. In Hospitals choosing to host observers, PHSOR supervising Professional Staff Members must be in good standing, must obtain the permission of the department chair sponsoring the observer, and must attest to their understanding of the responsibilities outlined in these policies and procedures.
- G. The regional GME department is responsible for working with human resources to develop standardized on-boarding materials for Hospitals who choose to host observers.
- H. The number of observers present must not interfere with the training opportunities and accreditation of Providence-sponsored education programs.

## **Article XVII. ADDITIONAL POLICIES**

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

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

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

Admission is arranged by contacting Access Services at which time a provisional diagnosis must be given. Admissions will fall into three basic categories - emergency, urgent and elective. All categories of admission shall be reviewed as necessary by the respective Hospital Chief Executive and President or their designees, to determine priority when an admission for a specific day is not possible.

The initial assessment and treatment should be accomplished within a time frame commensurate with the patient's severity of illness, not to exceed twenty-four hours for newborn well baby and as determined by Neonate department policy, twenty hours in the psychiatric units, twelve hours on the general floors or twenty-four hours for critical access hospitals on the general floors, four hours in the special care units, or twelve hours for critical access hospitals in the special care units. The admitting Member or Member designee will be responsible to evaluate each patient and document findings in the progress

notes at least every twenty-four hours on the general floors, psychiatric units (excluding PWFMC CAPU), and special care units, as often as deemed necessary for newborn well baby and swing bed patients, at least six out of every seven days in rehabilitation units, and at least six out of every seven days in the PWFMC child and adolescent psychiatric unit (CAPU). Daily evaluation in the CAPU will be determined by the Member based on patient severity.

Rounding and progress note entry for patients who are medically stable and on custodial care, as designated by hospital policy, while awaiting placement for non-acute services will occur at a minimum of every seven days if they continue to be stable for discharge. The patients will be returned to regular rounding if acute medical issues arise.

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

B. Placement of Admissions:

1. **General Placement:** Whenever possible, patients shall be assigned to general areas in the Hospital appropriate to the patient's diagnosis. It is understood that occasionally it will be necessary to assign patients to other areas in order to assure optimum utilization of Hospital beds. At the point of first contact with the patient, a process is undertaken to obtain the appropriate and necessary information to match individual care needs with the level of care required and the appropriate setting. Transfer to other settings occurs based on assessed individual care needs and with attending Member's approval.
2. **Placement of the Disturbed Patient:** The admitting Member shall furnish Access Services with information to assure proper placement of the disturbed patient for the protection of patients, the Professional Staff, nursing staff and the Hospital. Certain principles are to be met in the care of the potentially suicidal patient:
  - a. Patients known or suspected to be suicidal shall be assigned to a room in keeping with their medical needs. If there are no appropriate accommodations available, the patient shall be referred, if possible, to another institution where suitable facilities are available.
  - b. The admitting Member must offer a patient known or suspected to be suicidal a behavioral health consultation and document this in the record.

3. **Placement in the Special Care Units:** If any questions as to the appropriateness of admission or discharge involving the Intensive Care Unit or Coronary Intensive Care Unit should arise, the resolution is to be made through consultation with the Medical Director of Unit or Chair of appropriate special care committee. Patients admitted and discharged from a Special Care Unit must meet admitting and discharge criteria as defined by the Professional Staff.

- C. Length of Stay: The attending Member is required to document the need for continuing hospitalization.

Upon request of the Utilization Review designee, the attending Member must provide written justification of the necessity for continued hospitalization, including an estimate of the additional number of days of stay required by the patient. This report must be submitted within 24 hours of receipt of such a request. Failure to comply with this policy will be brought to the Department Chair for action.

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

In the event of a death in the Hospital, the deceased shall be pronounced dead by a physician within a reasonable time. Death pronouncements may be made by nurses in accordance with the respective Hospital policy on death pronouncement. The body will not be released until an entry has been made and signed in the medical record of the deceased. If death occurs less than 24 hours after admission, the Medical Examiner is notified and the Medical Examiner releases the body. All mortalities require a complete discharge summary.

It shall be the duty of all Members to obtain approval for autopsies whenever possible. An autopsy may be performed by the Hospital pathologist only with a written consent, signed in accordance with State law. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours and the complete protocol should be made a part of the medical record within two months.

- E. Transfer of Patients: Once a patient is admitted to a Hospital (including the Emergency Room), the patient shall not be transferred to another medical care facility unless the following conditions are met:

1. The attending Member has written a transfer order;
2. Arrangements have been made for the patient's admission with the other facility, including concurrence of the receiving physician and the hospital's consent to receive the patient; and
3. The patient is considered sufficiently stabilized for transport.

All pertinent medical information necessary to insure continuity of care must accompany the patient, including documentation of whether or not the patient requests

cardiopulmonary resuscitation and whether an advance directive exists. A transfer demanded by an emergency or critically ill patient, or his/her legal representative if the patient is incapacitated, is not permitted until a Member has explained to the patient, or his/her legal representative, the seriousness of the condition, and generally not until a Member has determined that the patient's condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient, or his/her legal representative, refuses to sign the release, a completed form without the signature and a note indicating refusal to sign must be included in the patient's medical record. The above is also applicable when a transfer is necessitated due to the services not being available at the Hospital.

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

1. Members with clinical privileges; and
2. Registered nurses with the following qualifications and for the following types of patients:
  - a) Perinatal nurses who completed orientation and competency that include consequence management (two years or greater experience in labor and delivery preferred), and have accepted the requirements of the assignments may perform medical screening examinations in the absence of the Member or in collaboration with a Member.
    - i. Perinatal nurses will initiate contact with the Member to discuss findings of the medical screening examinations, and to obtain any orders.
    - ii. Following the evaluation and communication, the Member will provide direction to admit, observe, discharge, or transfer the patient.

Qualified medical personnel, as defined above, shall perform initial medical screening examinations in accordance with departmental policies and procedures.

G. Against Medical Advice (AMA) Discharges: When a patient requests discharge AMA, the attending Member shall determine whether the patient is competent to understand and appreciate the risks of leaving the Hospital without further treatment. A determination that the patient is competent may be made by the attending Member acting alone. A determination that the patient is not competent shall be confirmed by a second Member, preferably a psychiatrist, and documented in the patient's medical record.

If the patient is determined competent by the attending Member and requests discharge AMA, then, whenever possible, the risks of the decision should be explained to the patient by the attending Member or designee. The explanation should be witnessed when possible and the name of the witness and the fact that the explanation was given shall be documented in the patient's medical record. The patient shall be asked to sign a release form that is filed with the medical record. If the patient refuses to sign the release form, the refusal

shall be documented in the patient's medical record, including the names of any witnesses to the refusal.

Incompetent patients who seek to leave the Hospital may be subject to reasonable physical restraints as may be necessary, subject to the order of the attending physician with confirmation by a second Member, preferably a psychiatrist, and documented in the patient's medical record. The attending Member or designee shall notify Hospital administration that the patient is being detained involuntarily in the Hospital.

When the patient leaves the Hospital without an opportunity to be given an explanation of the risks of leaving, the medical record should include any attempts to explain the risks and to request that the patient sign a release form.

## **Section 2. Medical Records**

Epic is the legal electronic medical record of the PHSOR.

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

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

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

1. Patient name, address, date of birth, and legal representative, if appropriate;
2. For patients receiving behavioral health services, the patient's legal status;
3. Applicable details of any emergency patient care provided prior to arrival, including transfer agreements;
4. Evidence of patient's Advance Directives;
5. Evidence of patient's signed Informed Consent for all invasive procedures except venipuncture and intravenous therapy;
6. Member's initial assessment (History & Physical) including patient's chief complaint, history of present illness, medical history, physical examination, pertinent review of systems, pertinent personal and family history, diagnostic impressions. Where appropriate, assessment of emotional, behavioral, social, educational, nutritional and/or functional status is also noted;
7. Member's treatment plan;
8. Orders for admission status, all diagnostic and therapeutic tests performed and all subsequent findings and results;
9. Member's report of all operative and invasive procedures performed;

10. Progress Notes by a Member or authorized practitioner; all patient reassessments, revisions to the treatment plan, clinical observations, and patient responses to treatment are in the Progress Notes;
11. Every medication ordered or prescribed for an inpatient, and every medication dispensed to, or prescribed for, an ambulatory patient or an inpatient at discharge;
12. Transfer summary and referrals, as applicable;
13. Member's Discharge Summary as delineated in Section 2 (H); and
14. Autopsy report, if applicable.

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

If a complete history and physical examination, or prenatal record, has been performed within thirty (30) days of a patient's Hospital admission by a Member, a durable, legible copy of the H&P may be used for the medical record. There must be an interval note subsequent to admission and prior to the procedure that includes any documented changes of the patient's history and physical status.

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

In cases involving anesthesia where there is no credentialed proceduralist to document the interval note including, but not limited to dental procedures and imaging studies, the Anesthesia provider's documented pre-anesthesia assessment will serve as the interval note.

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

C. Preoperative Diagnosis and Operative Procedure Reports: The patient's preoperative diagnosis shall be recorded in the medical record by the attending Member prior to any operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia. Operative reports shall be completed following an operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia, including procedures in the Cardiovascular Lab and Endoscopy. Such reports must include:

1. Name of the Member and all assistants;
2. Date of procedure
3. Procedure(s) performed;
4. Description of procedure(s);
5. Findings;
6. Any Estimated blood loss;
7. Any Specimens removed;
8. Postoperative diagnosis

Operative reports shall be completed by the Member within 24 hours of the procedure. An operative progress note including the elements noted above shall be entered in the medical record immediately after the procedure to provide pertinent information for Members and Practitioners providing patient care.

D. Anesthesia Record: The medical record of patients receiving anesthesia, with the exception of local only, shall include:

1. A record of the pre-anesthesia patient visit;
2. The anesthesia record; and
3. A record of the post-anesthesia patient visit or evidence that the patient meets discharge criteria as set by the Anesthesia service.

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

E. Teaching Cases: The attending Member, when acting as a preceptor, shall authenticate all history and physical examinations, operative reports, and discharge summaries recorded by Practitioners enrolled in an authorized training, residency or fellowship program.

F. Consultations: Consultations shall document a review of the patient's medical record by the consultant, pertinent findings from the patient examination, and the consultant's opinion and recommendations in the patient's medical record. When operative or invasive procedures are anticipated, the consultation note shall, except in documented emergency situations, be recorded prior to the procedure. A consultation report may be used in lieu of an H&P if it contains the pertinent required data and is performed within 24 hours of admission and prior to an operative or invasive procedure, or a potentially hazardous diagnostic procedure.

G. Reports: Reports of pathology and clinical laboratory examinations, radiology reports, nuclear medicine examination or treatment reports, anesthesia records, and reports of any other diagnostic or therapeutic procedures, should be completed promptly, authenticated, and maintained in the medical record, upon completion. All critical test results, as determined by the department, shall be reported to the ordering practitioner, with a verbal confirmation of the results by the ordering practitioner.

H. Discharge Summary: All medical records shall be as complete as possible at discharge and the discharge summary shall include:

1. A concise summary of the reasons for hospitalization;
2. Significant findings;
3. Hospital course;
4. All procedures performed and treatment rendered;
5. AJCC (American Joint Committee on Cancer) staging where applicable;
6. Final diagnoses including all diagnoses treated at this encounter;
7. Patient's condition at discharge;
8. Instructions regarding diet, medication, activity level and follow-up care; and
9. Post-hospital instruction (as described below).

A discharge summary is required for any patient: 1) with a greater than 48-hour hospitalization, 2) with an admission to a critical care unit or special care nursery, 3) with a transfer to an acute care facility, 4) with an admission to behavioral health, 5) who is a newborn with complications or greater than 96 hour hospitalization or 6) who expires.

A discharge progress note may be substituted for the discharge summary for a patient: 1) with a less than or equal to 48- hour hospitalization, 2) with an uncomplicated vaginal delivery who has a less than 72 hour hospitalization or 3) who is a newborn infant with a normal, uncomplicated course (the Newborn Provider Evaluation may be substituted for the discharge progress note).

- I. Post-Hospital Instruction: At discharge, the patient or representative will be provided with discharge instructions. The instruction should be appropriate for the medical condition, operative, invasive or diagnostic procedure for which the patient was hospitalized and should be communicated in lay terms. The completed discharge form can serve in lieu of other written discharge instructions.
- J. Ambulatory Surgery (Day Surgery) Records: A short form medical record, in addition to the operative/procedure report, is acceptable in ambulatory surgery. The short form shall include patient identification data, a medical history, physical findings, therapeutic and diagnostic orders, documentation of all treatment, post-operative assessment, information sufficient to substantiate the diagnosis and treatment, reports of procedures, tests and results, diagnostic impressions, patient disposition and post-hospital instructions. The medical record shall be authenticated by the attending Member.
- K. Emergency Medical Record: When emergency care is provided, an emergency medical record shall include the time and method of arrival, patient's physical examination and findings, treatment rendered, conclusions at the termination of treatment including final disposition, patient's condition at discharge, and post-hospital instructions (including a work release, if applicable) or follow-up care. The Emergency Medical Record shall be completed within 48 hours after discharge.

If a patient is transferred to another facility, the transfer process shall be fully documented in the medical record. If a patient leaves the Hospital against medical advice (AMA), this shall also be noted. A copy of the record of emergency services provided shall be communicated to the Member, practitioner or agency responsible for any follow-up care.

- L. Authentication: All entries in the medical record shall be electronically authenticated either by written signature or electronically (computer authentication). The Member must have a signed statement on file that he/she alone will utilize the computer key code. In cases when paper forms are necessary, such as downtime procedures, all paper forms must be dated, timed and signed by the appropriate Member.
- M. Symbols and Abbreviations: An official record of prohibited abbreviations is maintained by Health Information Management (HIM). HIM will also keep a Reference List of Commonly Used Medical Abbreviations.
- N. Order Sets: Order sets are standardized sets of orders based on patient diagnosis, Member instruction, location and Oregon Region Pharmacy and Therapeutics Committee protocols. Order sets must be authenticated by the appropriate Member or authorized practitioner.
- O. Availability of Records: The medical records of patients being treated in the Hospital are available to appropriate Members and authorized Practitioners through the EHR.

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

- P. Access to Records: Access to patient medical records shall be afforded to Members for bona fide studies and research consistent with the preservation of confidentiality of personal information concerning the individual patients and Members. Members desiring to conduct research involving the review of patient medical records must submit a letter to the President explaining the purpose and conduct of the research. The HIM Director, or designee, will arrange a schedule for the medical record review upon receipt of written approval from the President.

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

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

A complete medical record at the time of patient discharge encompasses all the applicable items specified in this Section 2(A).

When a Member has a scheduled absence from his/her clinical practice, this period of time will not be used for calculating medical record delinquency if Member's medical

records are current the week preceding the absence. The Member is obligated to notify the HIM Department in advance of such absences.

#### 1. Medical Record Notification

**First Notice** - If any Member's portion of the medical record is incomplete two weeks after patient discharge, the HIM will send an email and fax notice to the Member.

**Second Notice** - If the Member's portion remains incomplete three weeks after patient discharge, the HIM Department will send another email and fax notice to the Member.

**Third Notice** - If the Member's portion remains incomplete four weeks after patient discharge, the Member will be notified by telephone. Upon receiving a third notice all incomplete medical records are to be completed within three days. An email and fax notice to the Member will also be sent.

**Administrative Warning** - If the medical records that initiated the third notice are not completed within three days, the applicable President or designee will send a written notice of an imposed administrative warning to the Member by email, fax, and certified mail. The incomplete medical records continue to accrue administrative warnings on a weekly basis until all incomplete medical records are completed.

#### 2. Member Voluntary Resignation for Incomplete Medical Record

The fourth administrative warning for incomplete medical records in a 12-month period will be accepted as a voluntary resignation from the Professional Staff.

#### S. Operative, Invasive Procedure Report Notification, Administrative Warning, and Voluntary Resignation Policy: Operative and invasive procedure reports will be completed within 24-hours of the operative or invasive procedure.

##### 1. Operative and/or Procedure Report Notification:

**First Notice** - Whenever a Member fails to complete an operative or invasive procedure report within 24-hours following the procedure, the Hospital HIM Department will notify the Member immediately via email and fax, and will document the delinquency.

**Second Notice** - If any Member's portion of the Operative and/or Procedure Report is incomplete seven days, the HIM will send an email and fax notice to the Member. Reminder phone call will be at seven days after procedure regarding impending warning.

**Administrative Warning** - If the Operative and/or Procedure Report that initiated the second notice is not completed within 14 days, the applicable President or designee will send a written notice of an imposed administrative warning to the Member by email, fax, and certified mail.

The Operative and/or Procedure Reports will continue to accrue administrative warnings on a weekly basis until reports are completed.

## 2. Member Voluntary Resignation for Incomplete Operative, Invasive Procedure

The fourth time that a practitioner receives an administrative warning for incomplete Operative and/or Procedure Report in a 12-month period will be accepted, for review, as a voluntary resignation from the Professional Staff.

## 2.2 Electronic Health Record (EHR)

### Electronic Health Record Use and Responsibilities

The use of an Electronic Health Records (EHR) with Computerized Provider Order Management (CPOM) offers many advantages over paper medical records including driving standardization of best practices for improved patient care, the reduction of medical errors by integrating clinical decision support tools at the point of care delivery, and improved reporting mechanisms. Ensuring that all Members utilize the EHR as intended and to its fullest extent is critical to meeting these goals.

### Competency and Training

EHR training and/or competency assessment in the use of the EHR will be required prior to a Member obtaining access to the EHR system. Privileges and authorized clinical activity is dependent upon a Member obtaining access to the EHR. Only under emergency situations and/or MEC approval will a Member be granted exceptions.

### EHR Use and Etiquette

All Members will use CPOM for order entry. Verbal and telephone orders will be utilized only in urgent clinical situations. Any verbal orders and dictated reports will be authenticated electronically in a timely manner as specified in these Policies and Procedures. Members agree to “meaningfully use” the EHR to care for their patients. Meaningfully using the EHR currently includes the following responsibilities:

1. Members will update the active Problem list within the scope of their clinical expertise at each patient encounter.
2. Members are responsible to update the active Medication List at each encounter and to perform order management (medication reconciliation) at transition of care settings.
3. Members will accurately document electronically in the EHR with exceptions as granted by the MEC. Each note will be electronically reviewed and signed in the EHR with particular attention paid to ensuring the accuracy of automated documentation tools (such as copy/paste and template text).
4. Members will access the EHR to review patient information in a HIPAA compliant fashion; such as when directly serving patient care needs, reviewing results and outcomes after having served as part of a treatment team, in the context of undergraduate or graduate medical education, or as component of formal peer review and quality improvement activities.

### Documentation / Order Sets

Utilization of the various features of the EHR, such as note templates and order sets, will support efficiencies, foster preventive services, and facilitate the use of standardized terminology. Providence-sponsored collaborative workgroups consisting of physicians and other healthcare personnel will have the delegated responsibility to create, update, revise, and remove the Order Sets that populate the EHR.

#### Failure to properly use the EHR

Failure to complete EHR training will be considered an incomplete application for applicatns. Members must demonstrate/maintain EHR competency. Disregard of the EHR use and Etiquette principles outlined above will be deemed as a voluntary resignation of the member's Professional Staff membership and privileges

### **Section 3. General Conducts of Care**

- A. Orders: All Members will use CPOM for order entry. Medication orders must include drug name, dose, route, and frequency of administration. Diagnosis, condition or indication for use must be documented. Blanket reinstatement of previous medication orders is not acceptable. All medication orders must be rewritten in their entirety by the Member or authorized practitioner after surgery or transfer to another level of care.

Verbal Orders: All orders for treatment shall be in writing, dated, and timed. A verbal order may be accepted from a Member or authorized Practitioner if dictated to a licensed nurse, licensed pharmacist, respiratory therapist, for respiratory medications and treatments, and other designated staff within the scope of their practice in urgent clinical situations only. All verbal orders shall be read back to the Member or authorized Practitioner, with a verbal confirmation of the order received from the ordering practitioner. Verbal orders will be authenticated within 48 hours.

All drugs and medications administered to the patient shall be those approved through the Regional Pharmacy and Therapeutics Committee Formulary System Policy. Drugs for Institutional Research and Review Board approved clinical investigations may be exceptions to this rule. These investigational drugs shall be used in full accordance with the Institutional Research and Review Board Policies and Procedures.

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

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

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

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

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

When consultations are requested, direct Member-to-Member communication to convey the urgency, pertinent clinical data and specific question(s) is expected. The consultant shall make and sign a record of the findings and recommendations in every case. A satisfactory consultation shall include examination of the patient and the medical record. A written order is required to supplement the request for consultation.

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

D. Laboratory Studies:

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

E. Requests for Autopsies: To insure that autopsies are performed when indicated and the results are used as a source of clinical information in quality assessment and improvement activities, the following criteria should be used to identify deaths in which an autopsy should be considered are:

1. Deaths in which an autopsy may help to explain unknown and unanticipated medical complications to the attending Member;

2. All deaths in which the cause of death is not known with certainty on clinical grounds;
3. Deaths in which an autopsy may help to allay concerns of the family and/or the public regarding the death;
4. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies;
5. Deaths of patients who have participated in clinical trials (protocols) approved by the Institutional Research and Review Board;
6. Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction;
7. Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, and for which the attending Member determines that autopsy may disclose unexpected findings or illnesses. Examples include the following: (a) persons dead on arrival at the Hospital, (b) deaths occurring in the Hospital within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized;
8. Deaths resulting from high-risk infectious and contagious diseases;
9. All obstetrical deaths;
10. All neonatal and pediatric deaths;
11. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplant organs; and
12. Deaths known or suspected to have resulted from environmental or occupational hazards.

The patient's attending Member will determine if any of the above criteria pertain to the immediate situation and if so, request an autopsy from the family. The Member or other appropriate Hospital staff will obtain a family member's signature on the authorization form and document in the patient's chart that an autopsy is being obtained. The Pathology Department will notify the patient's attending Member when the autopsy is being performed. Findings from autopsies will be entered in the patient's medical chart and used in the mortality review conducted in quality assurance and improvement studies.

#### **Section 4. General Rules**

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

To gain informed consent, Proceduralist Members are required to utilize a Procedures, Alternatives, Risks and Questions (PARQ) Conference. In this PARQ conference the Member shall explain the following:

- (a) in general terms the procedure or treatment to be undertaken;
- (b) that there may be alternative procedures or methods of treatment; and
- (c) that there are risks, if any, to the procedure or treatment and/or the risks of not having the procedure.
- (d) answering any questions that may arise as a result of the discussion.

After giving the explanation specified above, the Member shall ask the patient if the patient wants a more detailed explanation. If the patient requests further explanation, the Member shall disclose to the patient in substantial detail the procedure, the viable alternatives, and the material risks, unless to do so would be materially detrimental.

The acronym PARQ can be written in the patient's chart indicating that the Member has explained the procedures (P), viable alternatives (A), material risks (R), if any, and asked if the patient has any questions (Q). If the patient requests further information, the Member can underline the PARQ chart notation to reflect the patient's request and that the physician provided more detailed information. The PARQ must be documented on the patient record. This documentation should occur prior to procedure unless unable to do so due to emergent nature of procedure.

It is important to note that informed consent to have one proceduralist Member perform a procedure is not considered informed consent for any other proceduralist Member. The proceduralist Member will make a written entry in the electronic medical record including a sentence to address this issue and PARQ review.

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

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

- B. Consent Forms: Each patient's medical record must contain evidence of the patient's or his/her legal representative's consent on the following forms:

- (a) Consent to Hospital services (Conditions of Service)
- (b) Hospital Consent form for Operation, Administration of Anesthetics and the Provision of other Medical Services (for any invasive procedure as defined by policy). The Hospital Consent form is an attestation on behalf of the patient or the patient's representative that they agree to the procedure listed and have received an informed consent from their proceduralist. The consent form will not be signed if the patient cannot attest to having received the informed consent and/or documentation of such informed consent does not exist.

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

The authenticated report shall be made a part of the patient's medical record. The disposition of this tissue shall be handled according to the Hospital's Disposition of Tissue Policy.

- 1. The following surgical specimens may be submitted to the Pathology Department for examination, but are exempted from the above requirement:
  - a. normal tissue removed to enhance operative exposure or to facilitate reconstructive procedures, such as rib, skin and bone fragments;
  - b. hardware or other appliances, the removal of which may be clearly documented radiologically;
  - c. therapeutic radioactive sources;
  - d. foreign bodies (i.e., bullets) that for legal reasons are given directly to law enforcement personnel;
  - e. specimens known to rarely, if ever, show significant pathologic changes and removal of which is recorded in the medical record, such as foreskins from newborns, cataracts, surgical scars, toenails, atrial appendages, meniscal fragments from the knee and fat from liposuction. Ophthalmic muscle tissues (including trabeculectomy) will be sent to Pathology at the discretion of the surgeon;
  - f. placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics;
  - g. teeth, provided the number, including fragments, is recorded in the medical record; and
  - h. in addition to the above, surgically excised tissues may be submitted to investigative laboratories for analysis or processing after receiving informed consent from the patient, if applicable, and after providing sufficient tissue for examination by the Hospital pathologist to arrive at a pathological diagnosis.

## **Section 5. Emergency Call**

Emergency Call: Each MEC will designate appropriate specialties for the published Emergency Call List. All Active and Active Provisional Physician Members of the Professional Staff who hold core privileges in their specialty areas are required to take emergency hospital call. Such call shall include emergency situations within the Emergency Departments, special care units and in general patient care and other service areas of the hospital.

A physician member on emergency call must respond by phone/pages within 15 minutes and when clinically indicated in person to the Hospital(s), within thirty (30) minutes.

If a physician member is taking simultaneous emergency call at another hospital and cannot respond within thirty (30) minutes, the Emergency Department will initiate a transfer due to lack of capability. If a physician member is performing scheduled surgeries while on emergency call the emergency on-call physician member must maintain reasonable physician back-up to still meet the intent for emergency call responsiveness of being available by phone/pages 15 minutes, and when clinically indicated in person, to the Hospital(s) within thirty (30) minutes. The emergency on-call physician member shall arrange ahead of time for another physician member of the Professional Staff with comparable privileges, to be responsible to respond to emergencies in the event that the emergency on-call physician member is unable to respond to an emergency call within thirty (30) minutes because he or she is performing a scheduled surgery. The on-call physician member involved in the scheduled or unscheduled procedure must respond by phone within 15 minutes to the Hospital(s). The on-call physician member cannot require that a patient be transferred to a second hospital for the physician's convenience.

If a physician member self-limits his/her practice to a "sub-specialty", then he/she is obligated to obtain appropriate support when designated to be emergency call. The Professional Staff Departments are responsible to establish an acceptable system of emergency call coverage and may require Courtesy physician members to take call as necessary and appropriate. In general the physician member will be assigned emergency call at his/her primary Hospital. Upon request of the member, the MEC may grant an exclusion to the mandatory call requirement on the basis of 25 years or more of cumulative service or 60 years of age or older.

For purposes of this policy, the ED physician shall make the determination of whether it is clinically indicated that the on-call physician member responds to a request in person in the Emergency Department. A physician member may not delegate his or her responsibility to a physician who is not a member. If the physician member is on the Hospital's emergency call list; has been requested by the treating physician member to appear at the hospital; and fails or refuses to respond by phone/page within 15 minutes or appear within 30 minutes; the hospital and the emergency on-call physician member may be subject to sanctions for violation of the EMTALA statutory requirements.

As part of routine responsibilities, the emergency on-call physician member is charged with the duty to accept patients transferred from other hospitals and may not refuse any transfer as long as the hospital has the capability and capacity to provide treatment.

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

The on-call physician member is responsible to provide care to any patient that requires emergency care, transfer or admission during the period that the physician member is taking call. This obligation is not waived by the fact that the patient may have an established relationship with another physician member. Once the patient is stabilized the emergency call physician member may contact the physician member who has an existing relationship with the patient and, with mutual agreement, arrange handoff of subsequent care to the physician member the patient has a pre-existing relationship with, if appropriate and safely feasible.

Continued membership on the Professional Staff is contingent upon satisfying emergency call responsibilities and compliance with EMTALA statutory requirements.

## **Section 6. Confidentiality of Credentialing/Privileging Information**

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

- A. The OCC, OMEC and MEC;
- B. The Department Chair or designee;
- C. The President or designee;
- D. The Chief Executive or designee on a need-to-know basis and with knowledge of the President;
- E. Quality Management and Medical Staff Services personnel;
- F. Any body entitled by law.

The applicant or Member may review his/her file in the presence of the Department Chair, or the Chair's designee, as long as the confidentiality of the source is maintained, if necessary. All credentials files are the property of the Professional Staff and PHSOR, and may not be removed from the Hospital premises for any purpose, unless specifically approved by the OMEC for purposes such as audits required by delegation agreement. Any request received for the above information from outside agencies, by subpoena, by any person or agency other than those noted above, shall be referred by the Medical Staff Coordinator to the President or the Chief Executive.

## **Section 7. PHSOR Internet Access and Electronic Mail Accounts**

- A. Members and their office staff may obtain limited Internet access through the PHSOR firewall, and electronic mail accounts on the PHSOR servers.
- B. Members and their office staff shall be subject to the PHSOR policies and procedures on appropriate Internet and e-mail use (a copy of such policies and procedures shall be included in the information packets applicants receive when applying for Professional Staff membership).
- C. Use of the Internet through PHSOR firewall is for business purposes only, with occasional personal use permitted with discretion. PHSOR employs techniques to limit access to inappropriate Internet sites. Use of the Internet by individuals is monitored by PHSOR.

Some applications and sites on the Internet may not be properly displayed through the PHSOR firewall.

## **Article XVIII. CONFLICT OF INTEREST**

Conflict of interest occurs when personal interests or activities influence or appear to influence actions and decisions. Professional Staff Members must avoid activities and relationships that may impair independent judgment and unbiased decision-making. A Professional Staff Member is considered to have a conflict of interest when they, or any of their family members or associates; receive financial or other significant benefit as a result of their position at Providence, have the opportunity to influence Providence business, administrative or other decisions in ways that could lead to personal gain or advantage, compete to the disadvantage of Providence, have a compensation agreement with Providence or have an ownership or investment in any entity with which Providence does business (refer to PROV-GOV-208 and any other conflict of interest specific policy that may be implemented by Providence and is applicable to Members). If any such conflict occurs, it is the Member's responsibility to disclose the conflict of interest to the Department Chair and/or System Integrity Department.

### **Section 1. Committee Members**

Elected, appointed, and/or committee Professional Staff Members shall use good faith to disclose material financial and personal interests that may potentially lead to a conflict. The Member must declare the conflict and shall abstain from voting on the issues concerning the matter of conflict. The OMEC may take appropriate action when an elected, appointed, and/or committee Member fails to disclose the conflict.

### **Section 2. Department Chairs**

Department Chairs, Division Chiefs, and/or Section Chairs shall have the duty to delegate review of applications for appointment, reappointment, clinical privileges, and/or questions that may arise to another member if the department/division/section has a conflict of interest with the individual under review or could be reasonably perceived to be biased in the review process. It is acknowledged that in certain limited circumstances, the delegation of such review may not be practical -- for example, where a facility has a small medical staff. In such a case, the Department Chair, Division Chair or Section Chair shall engage the facility Chief Executive Officer or Chief Medical Officer to act as an independent advisor assisting in the review. The OMEC may take appropriate action when a Department Chair, Division Chief, and/or Section Chair fails to disclose the conflict and/or not engage the Chief Executive Officer or Chief Medical Officer as required.

## **Article XIX. CONFLICT RESOLUTION**

This process is designed to manage conflict between the Board and OMEC or MEC, and between the Professional Staff and the OMEC or MEC on issues including, but not limited to, proposals to adopt a rule, regulation, policy or an amendment thereto. The Conflict Resolution process does not apply to issues addressed through the Corrective Action and Fair Hearing Plan.

## **Section 1. Conflict Resolution between the Board and the OMEC or MEC**

The OMEC and MECs, in partnership with the Board, have established a process for addressing conflicting recommendations made by the Board and the OMEC or MEC that will make efforts to address and resolve all conflicting recommendations in the best interest of patients, the Hospital, the committees we serve, and the Members of the Professional Staff:

- 1.1 When the Board plans to act or is considering acting in a manner contrary to a recommendation by the OMEC or MEC, the President from the Hospital, or his/her designee, shall meet with the Board or a designated committee of the Board and seek to resolve the conflict through informal discussions. If informal discussions fail to resolve the conflict, the President from the Hospital, the Chair of the OMEC or the Chair of the Board may request initiation of a formal conflict resolution process.
- 1.2 A Joint Conference Committee (JCC) will be established when a request is made to initiate a formal conflict resolution process. The JCC shall be comprised of two OMEC or MEC representatives and/or designees, as applicable, two Board members and/or designees, and the primary Hospital CEO, Regional CEO or designee. The JCC will meet within thirty (30) days of the initiation of the formal conflict resolution process to address the conflict.
- 1.3 If the JCC cannot produce a resolution to the conflict acceptable to the OMEC or MEC and the Board within thirty (30) days of this initial meeting, the OMEC or MEC and the Board shall enter into mediation facilitated by an outside party. The OMEC or MEC and Board shall agree upon the selection of the third party. The Board and the OMEC or MEC shall each designate up to three committee members to participate in the mediation. Any resolution shall be subject to the approval of the OMEC or MEC and the Board. If after ninety (90) days from the date of the initial request for mediation, the OMEC or MEC and Board cannot resolve the conflict, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.
- 1.4 If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the Hospital, the Board may take action which will remain in effect only until the conflict resolution process is completed.

## **Section 2. Conflict Resolution between the OMEC or MEC and the Professional Staff**

The MEC, in partnership with the Professional Staff, has established a process for addressing conflicting recommendations made by the OMEC, MEC and the Professional Staff to ensure consistent recommendations to the Board regarding medical staff issues. The MEC, in partnership with the Professional Staff, will make best efforts to address and resolve all conflicting recommendations in the best interest of patients, the Hospital, the committees we serve, and the Members of the Professional Staff:

- 2.1 When the OMEC or MEC plans to act or is considering acting in a manner contrary to the position of the Professional Staff, the Chair of the OMEC, the President from the Hospital, or his/her designee, shall meet with the Professional Staff or representatives from that body and seek to resolve the conflict through informal discussions. If informal discussions fail to resolve the conflict, the Chair of the OMEC, the President from the Hospital may request initiation of a formal conflict resolution process.
- 2.2 A meeting of an equal number of representatives from the OMEC, the MEC and the Professional Staff will be held within thirty 30 days from the request for a formal conflict resolution process.
- 2.3 If the OMEC, MEC and Professional Staff representatives cannot produce a resolution to the conflict acceptable to the OMEC, the MEC and the Professional Staff within thirty (30) days of this initial meeting, the OMEC, the MEC and the Professional Staff shall enter into mediation facilitated by an outside party. The OMEC, MEC and Professional Staff shall agree upon the selection of the third party mediator. The OMEC, MEC and the Professional Staff shall each designate up to three committee members to participate in the mediation. Any resolution shall be subject to the approval of the OMEC, the MEC and the Professional Staff. If after ninety (90) days from the date of the initial request for mediation, the OMEC, MEC and Professional Staff cannot resolve the conflict, the Professional Staff shall have the authority to act on the issue that gave rise to the conflict. An affirmative majority vote of the Active Members who respond is required to confirm the position of the Professional Staff.
- 2.4 If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the Hospital or Region, the Board may take action which will remain in effect only until the conflict resolution process is completed.
- 2.5 In addition to the formal conflict resolution process herein described, the President or the Chair of the OMEC may call for a meeting of the Professional Staff at any time and for any reason in order to seek direct input from the Members, clarify any issue, or relay information directly to the Members, the Board or Administration.

## **Article XX. COMMUNICATION WITH THE BOARD**

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

- A. Through the Chief Executives as designees of the Board;
- B. Through the Medical Executive Committees and the Oregon Medical Executive Committee;
- C. Through the physician representation on the Board;
- D. Through the Oregon Quality Committee of the Board.

**Article XXI      ADOPTION**

These policies shall be acted upon by the OMEC with prior notification to the Professional Staff, and prior opportunity for review and action from the MEC, and shall be effective not less than 45 days after OMEC recommendation, and Board approval.

## **Providence Health & Services – Oregon Exhibit A**

### **Oregon Region General Operating Policies Pertaining to Members (This is not an inclusive list of all GOPs)**

#### **Policy Title**

Abuse Identification and Intervention  
Advance Directives  
Central Line Placement & Verification Adult and Pediatric  
Clinical Alarms  
Code Blue Medical Emergency Adult and Pediatric  
Communication of Unanticipated Outcomes  
Consent and Refusal of Consent for Procedures  
Critical Value Notification  
Deep Procedural Sedation by Non-Anesthesia SIP - Adult  
Determination of Death by Neurologic Criteria in Adults & Children  
Discharge of Patients against Medical Advice  
Emergency Call Physician Obligations  
Emergency Medical Treatment and Active Labor Act (EMTALA) Patient Transfers  
Between facilities  
Event Reporting Using DATIX (UOR)  
Inpatient Leave of Absence  
List of Prohibited Abbreviations in the Medical Record  
Medication Reconciliation  
Moderate Procedural Sedation by Non-Anesthesia LIP – Adult  
Notification of Mental Illness  
Physician Orders for Life Sustaining Treatment  
Physician Assisted Suicide  
Restraints or Seclusion  
Resuscitation and Emergency Interventions During Hospitalization  
Rights and Responsibilities of patients  
Statement on Abortion  
Transfer and Direct Admit of Patients to Acute Care Facilities  
Universal Protocol for Invasive Procedures  
Verbal and Telephone Orders

The Professional Staff Policies and Procedures were officially reviewed and deemed current by the OMEC and the Board:

<b>Review Date</b>	<b>OMEC Approval</b>	<b>Review Date</b>	<b>Board Approval</b>
3/8/12 Excludes PHRMH	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	4/13/12 Excludes PHRMH	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
6/14/12 Excludes PHRMH	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	7/13/12 Excludes PHRMH	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
7/12/12 Excludes PHRMH	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	7/13/12 Excludes PHRMH	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
9/13/12	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	9/14/12	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
11/9/12	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	11/10/12 Excludes PHRMH	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
12/13/12	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	12/14/12 Excludes PHRMH	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
1/10/13	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	1/11/13 PHRMH added	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
2/13/13	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	2/14/13	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
4/11/13	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	4/12/13	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
5/9/13	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	5/10/13	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
5/9/13	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	7/12/13	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
7/11/13	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	7/12/13	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
9/12/13	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	9/13/13	<b>Authenticated</b> _____ Dave Underriner, Chief Executive Officer
2/13/14	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	2/14/14	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
6/12/14	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	6/13/14	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
9/11/14	<b>Authenticated</b> _____ Douglas Koekkoek, MD, Co-Chair, OMEC	9/12/14	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
1/8/15	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	2/13/15	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
2/12/15	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	2/13/15	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
3/12/15	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	4/10/15	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
5/14/15	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	5/15/15	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
7/9/15	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	7/10/15	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer

3/10/16	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	4/15/16	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
4/14/16	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	5/13/16	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
6/9/16	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	7/8/16	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
9/8/16	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	9/9/16	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
12/8/16	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	12/9/16	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
3/9/17	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	3/10/17	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
4/13/17	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	4/14/17	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
5/11/17	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	6/9/17	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
7/13/17	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	7/14/17	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
9/14/17	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	9/15/17	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
11/9/17	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	11/10/17	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
12/14/17	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	12/15/17	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
1/11/18	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	2/9/18	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
2/8/18	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	2/9/18	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
4/12/18	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	4/13/18	<b>Authenticated</b> _____ Theron Park, Chief Executive Officer
12/13/18	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	12/14/18	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
2/14/19	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	2/15/19	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
3/14/19	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	3/15/19	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
4/11/19	<b>Authenticated</b> _____ <b>Steve Freer. MD, Co-Chair, OMEC</b>	4/12/19	<b>Authenticated</b> _____ <b>Lisa Vance, Chief Executive Officer</b>
4/11/19	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	5/10/19	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
7/11/19	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	7/12/19	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
8/8/19	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	8/9/19	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer

12/12/19	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	12/13/19	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
12/12/19	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	3/13/20	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
4/9/20	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	4/10/20	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
5/14/20	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	5/15/20	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
8/13/20	<b>Authenticated</b> _____ Steve Freer. MD, Co-Chair, OMEC	8/14/20	<b>Authenticated</b> _____ Lisa Vance, Chief Executive Officer
10/8/20	<b>Authenticated</b> _____ <b>Steve Freer. MD, Co-Chair, OMEC</b>	10/9/20	<b>Authenticated</b> _____ <b>Lisa Vance, Chief Executive Officer</b>
3/11/21	<b>Authenticated</b> _____ <b>Steve Freer. MD, Co-Chair, OMEC</b>	3/12/21	<b>Authenticated</b> _____ <b>Lisa Vance, Chief Executive Officer</b>
8/12/21	<b>Authenticated</b> _____ <b>Steve Freer. MD, Co-Chair, OMEC</b>	8/13/21	<b>Authenticated</b> _____ <b>Lisa Vance, Chief Executive Officer</b>
1/13/22	<b>Authenticated</b> _____ <b>Steve Freer. MD, Co-Chair, OMEC</b>	1/14/22	<b>Authenticated</b> _____ <b>William Olson, Chief Executive Officer</b>
6/9/22	<b>Authenticated</b> _____ <b>Elizabeth Ransom. MD, Co-Chair, OMEC</b>	6/10/22	<b>Authenticated</b> _____ <b>William Olson, Chief Executive Officer</b>
7/14/22	<b>Authenticated</b> _____ <b>Elizabeth Ransom. MD, Co-Chair, OMEC</b>	7/15/22	<b>Authenticated</b> _____ <b>William Olson, Chief Executive Officer</b>