



**CREDENTIALING PLAN**

**FOR**

**ALLIED HEALTH PROFESSIONALS  
AND CLINICAL STAFF**

Approved by PH&SA Region Board

  
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**Charles Ryan, MD, Chair**

February 12, 2008  
Date

  
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**Cathy Gohring, MD, Chief of Staff**

February 12, 2008  
Date

## CREDENTIALING PLAN

### BYLAWS AND MEDICAL STAFF DOCUMENTS REFERENCE:

*Medical Staff Bylaws, Definitions, #5*

### OTHER CROSS-REFERENCE:

*Providence Alaska Medical Center - Credentials Policies and Procedures Manual*

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## I. PURPOSE

The Medical Executive Committee ("MEC") and the Providence Health & Services Alaska (PH&SA) Region Board ("Board") have identified certain categories of non-physician healthcare professionals who are needed to provide patient care services at Providence Alaska Medical Center. These healthcare professionals (hereinafter referred to as – Allied Health Professionals "AHPs" and Clinical Staff) are not eligible to be members of the medical staff organization of Providence Alaska Medical Center ("PAMC").

The MEC and Board have agreed that the medical staff organization should be directly involved in the credentialing/authorization process for specific categories of healthcare professionals. These specific categories are defined within this Plan (see Attachment A).

In the interest of providing high quality of care at PAMC, meeting accreditation standards, licensing and other regulatory requirements, this Credentialing Plan was created to describe the mechanisms by which specific categories of healthcare professionals, permitted to provide services at PAMC are credentialed via medical staff organization mechanisms. (It should be noted that there may be additional types of healthcare professionals who provide services at PAMC who are authorized via alternative mechanisms, such as through a contracting department. Separate policies and procedures cover those arrangements.)

The purpose of this Credentialing Plan ("Plan") is to establish a process to assess, evaluate and review the qualifications and professional conduct of and quality and appropriateness of care provided by the AHPs and Clinical Staff who are determined to be eligible to provide patient care services at PAMC.

This Plan and all other related policies, procedures, rules, regulations and requirements related to the practice of the AHPs and Clinical Staff at PAMC do not constitute a contract of any kind whatsoever and are subject to change at any time without notice to applicants or to AHPs and Clinical Staff who provide services at PAMC.

## II. DEFINITIONS

**Allied Health Professionals (AHPs):** A licensed, certified or otherwise qualified healthcare professional who has been determined to be competent to provide services to patients, working collaboratively with and/or under the supervision of members of the medical staff and within the scope of the professional license, certification or other legal credential, in compliance with the circumstances and conditions approved by the Medical Executive Committee and Board. AHPs may be (but are not required to be) employees of PAMC. AHPs function under clinical privileges.

**Board:** The PH&SA Region Board of Providence Alaska Medical Center.

**Clinical Staff:** A licensed, certified or otherwise qualified healthcare professional who has been determined to be competent to provide services to patients, under the direct supervision of members of the medical staff and within the scope of the professional license, certification or other legal credential, in compliance with the circumstances and conditions approved by the Medical Executive Committee and Board. Clinical staff are not employees of PAMC. Clinical staff function under a defined "scope of services".

**Clinical Supervisor:** An employed manager of the unit or department who is responsible for coordination and providing documentation of the demonstrated competence of assigned Clinical Staff.

**Medical Staff Services Department ("MSS"):** The department of PAMC that coordinates and provides credentialing services for Allied Health Professionals and Clinical Staff covered in this Plan.

**Physician:** The term "physician" when used in this document shall also include dentists and podiatrists.

**Plan:** The Allied Health Professionals and Clinical Staff Credentialing Plan.

**Delineation of Privileges:** Refers to the permission granted to an Allied Health Professional to render specific patient services. Privileges are based on the AHP's licensure, education, training, experience, and demonstrated competence, as well as the limitations defined by PAMC for medical staff, operational or risk management reasons. The performance of privileges may be subject to supervision requirements as well as limitations on the settings in which the services may be provided and the patient populations to which services may be provided. In this document, the terms "delineation of privileges" and "scope of services" are used interchangeably; however, privileges are reserved for AHPs and Clinical Staff may not be granted clinical privileges.

**Scope of Services:** The services, which Clinical Staff are permitted to perform at PAMC, based on licensure, education, training, experience, and demonstrated competence, as well as the limitations defined by PAMC for medical staff, operational or risk management reasons. The performance of the scope of services is subject to supervision requirements as well as limitations on the settings in which the duties may be performed and the patient populations to which services may be provided. In this document, the terms "delineation of privileges" and "scope of services" are used interchangeably; however, privileges are reserved for AHPs and Clinical Staff may not be granted clinical privileges.

### **III. QUALIFICATIONS**

#### **Basic Qualifications**

An AHP or Clinical Staff practitioner shall not be granted authority to provide patient care services or given an application for credentialing until the Board has authorized and approved the provision of such services at PAMC by the category of AHP or Clinical Staff.

An AHP or Clinical Staff within an approved category shall not be granted authority to provide patient care services unless the AHP or Clinical Staff meets all applicable requirements and qualifications as stated in this Plan and has been granted a scope of services or scope of privileges in accordance with this Plan.

If applicable, have a current, unrestricted license, certification or registration to practice in Alaska and have never had a license, certification or registration to practice revoked or suspended.

If applicable, have a current, unrestricted DEA Registration.

Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil penalties for the same;

Have never been and are not currently excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care programs.

Have never had a scope of practice or clinical privileges denied, revoked, resigned, relinquished or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct; and

Have never been convicted of, or entered a plea of guilty or no contest to, any felony relating to controlled substances, illegal drugs, insurance, health care fraud or abuse, violence or a crime against a person.

An applicant shall not be denied Allied Health Professional or Clinical Staff membership or privileges because of ancestry, gender, sexual orientation, faith, or on the basis of any other criterion unrelated to the delivery of quality patient care in the Medical Center.

**Professional Liability Insurance Requirements (MS Policy 900-060)**

Evidence of possession of professional liability insurance, a minimum of \$500,000 and \$1,500,000 is required. This requirement is waived for PAMC employed AHPs.

**Health Status**

AHP's and Clinical Staff must attest to their ability to provide requested services. Confirmation is provided during the verification and evaluation and decision-making process.

**Orientation**

AHP's and Clinical Staff must receive a general orientation to PAMC and to the patient care area(s) in which each practitioner will be providing services. Medical Staff Services Department ("MSS") will provide the general orientation program for Clinical Staff and non-employed AHP's. An appointment will be scheduled by the MSS with the patient care area for an orientation where they will be providing services.

Only AHP's or Clinical Staff who meet qualifications as determined under the processes outlined in this Plan are eligible to provide services at PAMC.

**IV. Responsibilities**

**Basic Responsibilities**

Each AHP and Clinical Staff shall:

1. Abide by all applicable state and federal laws regulating healthcare providers, as well as by rules and regulations and all other lawful standards, policies and rules of PAMC.
2. Cooperate with and participate, as requested by a Medical Executive Committee, in committee activities.
3. Submit to such physical and/or mental examination(s) or provide verification of health status as may be required to verify the AHP's or Clinical Staff's ability to fully meet his/her responsibilities and/or to perform the requested scope of services.

4. Comply with policies, procedures, rules, regulations and requirements, which relate to the provision of services by AHP's or Clinical Staff at PAMC.
5. Document patient medical records in a complete and timely fashion to the extent required by State law and the Medical Staff Bylaws and Policies and authorized in the Category Description/Scope of Services.
6. At all times observe and promote the confidentiality of patient identifiable information.
7. Wear a PAMC provided nametag at all times while providing services at PAMC.
8. Maintain all other qualifications for the scope of services set forth in this Plan or the applicable AHP or Clinical Staff Category Description.

### **Relationship to Medical Staff**

AHP's and Clinical Staff are not members of the medical staff of PAMC and do not have voting privileges at medical staff meetings. AHP's and Clinical Staff may attend medical staff meetings only when appointed to a committee or department or requested to attend by the Medical Executive Committee or a Chair of a Department.

An AHP and/or Clinical Staff is obligated, to comply with the bylaws, policies, rules and regulations of the medical staff organization and hospital, which apply to the scope of services, provided by the AHP and/or Clinical Staff.

## **V. INITIAL CREDENTIALING AND/OR AUTHORIZATION PROCESS**

### **Eligibility for Application**

AHP's and Clinical Staff must be credentialed in accordance with this Plan. In order to be credentialed, AHP's and Clinical Staff must complete an application form. Only those AHP's and Clinical Staff who meet the following eligibility criteria shall be provided with an application:

1. Practices within a category approved by the Board;
2. Through a screening process, appears to meet licensing, certification, education, training and experience requirements of the applicable category;
3. Has not been excluded from any federal health program, including Medicare and Medicaid.

AHPs who will be seeking employment at PAMC are informed by the Human Resources Department of PAMC that employment as an AHP is contingent upon successful completion of the credentialing/privileging process administered by the medical staff organization of PAMC.

Those AHPs that will be potential employee's will be instructed by Human Resources of PAMC to contact the Medical Staff Office to obtain an AHP application and other application materials.

### **Demonstration of Qualifications**

At all times, the AHP or Clinical Staff is responsible for demonstrating the following qualifications:

1. Requisite professional education and training, licensure, certification and recertification, if required.
2. Demonstrated ability and judgment.
3. Relevant experience by clinical results.
4. Current competence to practice his/her profession and perform the requested scope of services.

5. Freedom from any significant physical, emotional or behavioral impairment (including the use of drugs or alcohol), which prevents the AHP or Clinical Staff from meeting the other qualifications for status and the requested scope of services.
6. The ability to communicate verbally and in writing in the English language.
7. Acceptable professional claims history.
8. Adherence to the ethics of the AHP's or Clinical Staff profession.
9. The ability to work cooperatively with others in the hospital setting and with healthcare professionals in a consistently cordial and productive manner.
10. Must adhere to the Ethical and Religious Directives for Catholic Health Care Services.

### **Application Process**

AHP's or Clinical Staff may obtain an application form from the Medical Staff Office. Once the AHP or Clinical Staff has obtained and completed an application form, he/she must return the application to the Medical Staff Office, along with all supporting documents and fees, which are required for his/her category.

### **Obligations of Applicant**

It is the applicant's obligation to provide sufficient information for the various individuals and committees charged with the responsibility of evaluating the applicant's qualifications for the requested scope of services. An application is not complete unless the application form is completed, all information required to be verified is provided, and any additional information necessary to evaluate the applicant's qualifications has been provided. The Supervising Physician/Medical Director(s) signature must be provided, prior to the application being processed. An application which has not been completed within 180 days of the date it was submitted shall be automatically withdrawn. An application becomes incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn. In either situation there shall be no entitlement to a hearing or appeal.

The applicant agrees that any misstatement in, or omission from, the application form is grounds for the Medical Center to stop processing the application. If permission to practice has been granted prior to the discovery of a misstatement or omission, permission to practice and clinical privileges or scope of services may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal.

### **Verification Procedures**

The Medical Staff Office will carry out verification procedures. Verification requirements for AHPs are as contained in the "Verification Methods and Requirements" document approved by the Medical Executive Committee and Board.

At a minimum, the following will be verified for all Clinical Staff applicants:

1. Source verification of licensure, certification and/or registration, as applicable to the Clinical Staff category.
2. Source verification of the highest level of training.
3. Verification of last employer (dates and services provided and/or job classification).

4. Reference checks and/or reference questionnaires completed by healthcare professionals who have worked with the Clinical Staff during the last two (2) years, and requirements as further defined by the specific Category Description.

Additional items may be verified, depending upon the Category Description.

### **Decision-Making Procedures**

AHP or Clinical Staff - Once an application for clinical duties is complete and all required information is received and verified, the applicable supervising physician/medical director; and/or Department Chair shall review the application for completeness. In the case of employed AHP's, the supervising physician/medical director shall interview the practitioner in lieu of or in addition to the Department Chair. For AHP's that are employed by their Supervising Physician/Medical Director, the Department Chair/designee shall review the application, all verified information and will interview the applicant. The Department Chair/designee shall forward a recommendation to the Credentials Committee.

A member of the Credentials Committee shall review the application materials and the recommendation of the Department Chair. An applicant may be granted temporary privileges, following review by the Credentials Committee and/or a representative of the credentials committee if the application and related information demonstrate the following criteria as per Joint Commission (MS 4.100):

1. The applicant has not had any significant malpractice judgments or settlements.
2. The applicant has not had any disciplinary actions or investigations by any licensing or certifying authority or healthcare facility.
3. The applicant has not had any restrictions, suspensions, probations, or revocations of the applicant's clinical services at a healthcare facility or managed care plan or of the applicant's professional license or certification.
4. The applicant has received positive references with respect to the applicant's competence and ability to work cooperatively with others in the hospital setting.
5. The applicant meets the applicable criteria and qualifications for all requested clinical duties.
6. There are no other indications that the applicant does not meet the qualifications for clinical duties.
7. The Department Chair/designee has made a favorable recommendation.

If the application meets all the above criteria, the Credentials Committee reviewer may recommend to the Credentials Committee that the applicant be granted temporary privileges (per Joint Commission standard MS 4.100). All recommendations by the Credentials Committee shall be forwarded to the Medical Executive Committee. Upon favorable review, a recommendation will be forwarded to the Board. The decision of the Board will be final.

If the Department Chair/designee or Credentials Committee makes an unfavorable recommendation or identifies a concern regarding the applicant's qualifications or competence, the Credentials Committee or a designee of the Credentials Committee shall interview the applicant and/or request additional information from the applicant or another source. A recommendation by the Credentials Committee shall be forwarded to the Medical Executive Committee. Upon review, a recommendation will be forwarded to the Board. The decision of the Board will be final.

No services may be provided by any AHP or Clinical Staff practitioner covered under this Plan until the AHP/Clinical Staff applicant has been notified that the authorization process has been completed and approval granted.

- AHP's with clinical privileges are processed in the same manner as physicians, podiatrists and dentists – See Credentials Policies and Procedures Manual.

## **VI. ADMINISTRATIVE FEES**

AHP's and Clinical Staff will be charged an application fee in the amount of \$500. This application fee will be collected at the time of initial application to defray costs associated with application processing and establishment of a credentials file. The Medical Executive Committee may impose additional dues or fees at its discretion.

AHP's and Clinical Staff will pay annual dues of \$50.00. Annual dues of \$50.00 shall be due and payable at the time of appointment, and thereafter on December 31<sup>st</sup> for the upcoming calendar year. A dues notice of payment will be mailed by November 30<sup>th</sup> of each year. Allied Health Professionals/Clinical Staff appointed within the last three months of the year (October, November, December) shall be exempt from paying dues during the current year. All new AHP applicants will be charged dues in 2007; all those on staff prior to January 2006 will begin payment dues at the end of 2007 on the schedule above.

Failure to pay dues by December 31<sup>st</sup> for the upcoming year (if December 31<sup>st</sup> falls on a weekend, payment is due by the following first business day) will result in the following with an appropriate delinquency notification:

1. January 1<sup>st</sup> – January 31<sup>st</sup> - Annual dues will double to \$100.00.
2. February 1<sup>st</sup> – February 28<sup>th</sup> – Annual dues increase to \$200.00.
3. March 1<sup>st</sup> – Allied Health Professionals/Clinical Staff membership and clinical privileges will be subject to voluntary relinquishment until dues of \$200.00 are paid in full.
4. April 1<sup>st</sup> – If dues of \$200.00 have not been received in the Medical Staff Services Department by April 1<sup>st</sup>, then the Allied Health Professional/Clinical Staff member must reapply.

## **VII. CREDENTIALS FILES**

Each AHP and Clinical Staff will have a credentials file, which is maintained by the Medical Staff Services Department.

Employed AHPs will also have a personnel file maintained in accordance with PAMC's policies and procedures.

## **VIII. SUPERVISION**

### **AHPs Subject to Supervision**

AHPs and Clinical Staff must have a supervising physician. A supervisor may be:

1. The physician who employs the AHP or Clinical Staff.
2. The Supervising Physician/Medical Director designated by a physician group, when a physician group employs or contracts with the AHP or Clinical Staff, and works for more than one member of the physician group.

3. The designated medical director of the patient care area/unit where the AHP or Clinical Staff provides services.
4. The physician who has contracted with PAMC to provide specific patient care services and the contract includes the AHP or Clinical Staff.
5. The designated clinical supervisor of the patient care area/unit where the employed AHP or Clinical Staff provides services.

A physician supervisor must be an active member in the same specialty as the AHP in good standing within the PAMC medical staff organization. The designated clinical supervisor must be employed by Providence Alaska Medical Center.

An AHP or Clinical Staff may have multiple physician or clinical supervisors, as permitted by law (for example: a nurse midwife is an independent contractor, has his/her own practice, and routinely works with more than one OB/GYN physicians). A Supervising Physician/Medical Director form must be signed by each active staff member agreeing to be a Supervising Physician/Medical Director.

#### **IX. PERFORMANCE EVALUATIONS of AHP or Clinical Staff**

The Supervising Physician/Medical Director of an AHP or Clinical Staff must annually sign an acknowledgment and complete an evaluation form for each AHP or Clinical Staff that he/she supervises, in which he/she accepts responsibility for appropriate supervision of the services provided by each AHP or Clinical Staff under his/her supervision. In addition, the appropriate PAMC manager will be asked to complete an evaluation form on the AHP and/or Clinical Staff serving in his/her area.

The quality of care provided by AHP or Clinical Staff shall be reviewed on an ongoing basis through the regular quality improvement programs of PAMC, including without limitation, case management processes, and, as applicable, by professional review committees of the medical staff. Employed AHPs quality of care shall be reviewed according to the Human Resources PAMC policy. Any concerns regarding the quality or appropriateness of care provided by an AHP identified during such review processes shall be referred to an appropriate review committee. Any concerns regarding the supervision of an AHP or Clinical Staff by a medical staff member shall be referred to the appropriate medical staff department or review committee.

**Reappointment:** (*Reappointment procedures described in the Credentials Policies and Procedures Manual apply to AHP and Clinical Staff.*)

The quality management department shall develop routine and ongoing procedures to screen and review cases in which AHPs and Clinical Staff actively performed patient care services. An AHP or Clinical Staff "actively" performed patient care services if the AHP/Clinical Staff exercised his or her professional judgment or performed delegated medical functions in the diagnosis or treatment of patients. A report shall be prepared of all screened/reviewed cases. Cases in which problems are identified shall be referred to a medical staff review committee for further evaluation.

Clinical Staff and employed AHP evaluations shall be provided by the clinical supervisor who supervises the area/unit in which the Clinical Staff or employed AHP most frequently provides care. These evaluations will be forwarded to the Medical Staff Services Department.

The Medical Staff Services Department shall provide verification of the AHP's or Clinical Staff's licensure status, and malpractice claims history within the last two years, and query the National Practitioner Data Bank if applicable.

The applicable Department Chair/designee shall evaluate all assembled information and make a determination regarding the competency of the AHP or Clinical Staff. The Department Chair/designee may conduct or appoint an ad hoc committee to conduct an evaluation of the care provided by an AHP or Clinical Staff, may interview, and/or may request additional information. The Department Chair/designee makes a recommendation regarding continued scope of services to the Credentials Committee.

The Credentials Committee (through one of the members of the committee or through assignment to a physician medical staff member) shall evaluate the recommendation of the Department Chair/designee and all assembled information and make a determination regarding the competency of the AHP or Clinical Staff.

If the Credentials Committee does not identify any concerns regarding the quality or appropriateness of the scope of services provided by the AHP or Clinical Staff, the Committee's findings shall be documented in the credentials file.

If the Credentials Committee has concerns regarding the competency of any AHP or Clinical Staff, the Credentials Committee may set up an ad hoc committee to meet with the AHP or Clinical Staff and the Supervising Physician/Medical Director. The AHP or Clinical Staff may be required to participate in an improvement plan. Alternatively, the Credentials Committee may recommend restriction, suspension, modification or termination of all or a portion of the AHP's or Clinical Staff's scope of services or any other action the Credentials Committee deems appropriate under the circumstances. In the event the Credentials Committee makes a recommendation to restrict, suspend, modify or terminate the scope of services of an AHP or Clinical Staff, the AHP or Clinical Staff shall be entitled to an interview with an ad hoc committee established by the Credentials Committee for that purpose (see Section XI, Grievance Procedures).

In the event an AHP or Clinical Staff fails to comply with the procedures for evaluation, the Credentials Committee may automatically suspend the practitioner's scope of services until the practitioner complies with the procedures. Such automatic suspension shall not entitle an AHP or Clinical Staff to any grievance procedures under this Plan.

**X. REVIEW OF SPECIFIC CONDUCT OR CARE/CORRECTIVE ACTION**

Whenever the activities or professional conduct of an AHP or Clinical Staff adversely affects or is reasonably likely to adversely affect patient safety or the delivery of quality patient care or are disruptive to the organization's operations, the matter shall be handled in accordance with MS 980-050 Code of Conduct Policy.

**Automatic Termination**

The scope of services and status as an AHP or Clinical Staff shall terminate immediately, without review, in the event that any one or more of the following occurs:

The medical staff membership and/or clinical privileges of the employing physician is terminated for any reason.

**OR**

1. The AHP or Clinical Staff is no longer employed by his/her Supervising Physician/Medical Director or the physician no longer agrees to act as a supervisor, for any reason.
2. The AHP's or Clinical Staff's license, registration or other legal credentials expires, is revoked or is suspended.
3. The AHP is no longer employed by Providence Alaska Medical Center (if applicable).

## **Summary Suspension**

Whenever the conduct of an AHP or Clinical Staff requires that immediate action be taken to protect the life of or to reduce the likelihood of injury to the health or safety of any patient, prospective patient, employee, or other person present at PAMC, any one of the following individuals has the authority to summarily suspend all or any portion of the scope of services of the AHP or Clinical Staff: Chair of the Credentials Committee, a medical staff officer, a medical staff department chair, the Medical Executive Committee, Chief Medical Officer, PAMC Administrator or the Chief Nurse Executive.

A summary suspension is effective immediately upon imposition. It must be reported immediately to the Chief of the Medical Staff and the Chief Medical Officer, who will promptly notify the Credentials Committee Chair and the Medical Staff Services Department. The Chief of Staff shall promptly give oral notice, to be confirmed in writing, to the affected AHP or Clinical Staff and his/her supervising physician/medical director. Notice of same shall be sent simultaneously to the Credentials Committee Chair. The suspension will be handled per MS Policy 980-100 Investigation, Hearing and Appeals Plan.

## **XI. Fair Hearing and Appeal Process**

All AHP's will follow MS Policy 980-100 Investigation, Hearings and Appeal Plan.

- Employed AHPs will follow the current Human Resources PAMC policy.
- The procedural rights for Clinical Staff who are not employed by the Medical Center shall be as follows:
  - (a) In the event that a recommendation is made by the Medical Executive Committee that a Clinical Staff not be granted the scope of services requested or that a scope of services previously granted be restricted or terminated, the individual shall be notified of the recommendation. The notice shall include a specific statement of the reason for the recommendation and shall advise the individual that he or she may request a meeting with the Medical Executive Committee before its recommendation is forwarded to the Board for final action.
  - (b) If the Clinical Staff desires to request a meeting, he or she must make such request in writing and direct it to the CEO within 30 days after receipt of the written notice of the adverse recommendation.
  - (c) If a meeting is requested in a timely manner, it shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Clinical Staff and his or her employing or supervising physician shall both be permitted to attend and participate in the meeting. However, no counsel for either the Clinical Staff or the Medical Executive Committee shall be present.
  - (d) Following this meeting, the Medical Executive Committee shall make its final recommendation to the Board.

## **XII. CONFIDENTIALITY, IMMUNITY AND RELEASE OF LIABILITY**

### **Definitions:**

**PAMC Representative** refers to any person, entity or committee which participates or assists in or provides information for the review of the qualifications, competence, or professional conduct of or quality or appropriateness of care rendered by AHP or Clinical Staff who apply for or are granted services at PAMC, including without limitation, the following: the Board and members thereof; any committee appointed by the Board or members thereof; the Credentials Committee, the Medical Staff and its officers, committees and members; Supervising Physician/Medical Directors and employees, clinical supervisors, officers and agents of PAMC.

**Third Party(ies)** refers to any individuals or entities which provide AHP or Clinical Staff information to a PAMC representative.

### **Acknowledgements and Authorizations**

By applying for or providing services at PAMC, an AHP or Clinical Staff:

1. Authorizes PAMC representatives to solicit, provide and act upon AHP or Clinical Staff information bearing on the qualifications, professional ability and conduct, competence, quality and appropriateness of care and other criteria, including within limitation, soliciting information from other healthcare facilities and providers, previous employers and the National Practitioner Data Bank, state regulatory agencies and other relevant data bases.
2. Authorizes third parties to provide information, including otherwise privileged and confidential information, concerning the AHP or Clinical Staff to PAMC representatives.
3. Agrees to waive any claims against a PAMC representative or third party who acts in accordance with this section.
4. Acknowledges that PAMC and its medical staff and other representatives have duties to report certain conduct or actions in accordance with state and federal law.

### **Privileges and Immunities**

All activities of the Credentials Committee, other committees and departments of the medical staff organization and the Board related to the review of AHPs or Clinical Staff are deemed to be conducted on behalf of PAMC, and such committees are acting on behalf of the Board in conducting their activities. All activities under this Plan and the other functions described in this Plan shall be conducted pursuant to the quality improvement programs of PAMC and shall be confidential and privileged and the individuals who participate in such activities shall be immune from liability.

### **Confidentiality of Information**

All AHP or Clinical Staff information collected or presented by any PAMC representative or third party shall, to the fullest extent permitted by law, be confidential and shall not be subject to disclosure to anyone other than a PAMC representative, and shall not be used in any way except as provided herein, or as otherwise required by law.

### **Immunity from Liability**

**For Action Taken.** Each PAMC representative shall be immune and exempt to the fullest extent permitted by law, from liability to an AHP or Clinical Staff for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a PAMC representative.

**For Providing Information.** Each PAMC representative and all third parties shall be immune and exempt to the fullest extent permitted by law from liability to an AHP or Clinical Staff for damages or other relief by reason of providing information, including otherwise privileged or confidential information to a PAMC representative concerning an AHP or Clinical Staff.

**Activities and Information Covered.** The confidentiality and immunity provided by this Plan shall apply to all acts, communications, reports or disclosures performed or made in connection with activities related to peer review of AHP's or Clinical Staff concerning, but not limited to:

1. Applications and reviews of an AHP's or Clinical Staff's scope of services.
2. Investigations and corrective action, including summary suspension and automatic suspension.
3. Interviews.
4. Medical staff and Board activities related to monitoring, maintaining and improving the quality and efficiency of patient care, appropriate utilization, and appropriate professional conduct.
5. Other peer and professional review recommendations or reports, reports to federal, state or local reporting bodies, including, but not limited to, the National Practitioner Data Bank, quality assurance bodies and the regulatory agencies, as well as other like reports.
6. All peer review activities and actions whatsoever.

Releases. Each AHP or Clinical Staff shall be required to and shall execute general and specific releases in accordance with the provisions of the Plan. Execution of such releases shall be a prerequisite to the processing of applications for clinical duties. Execution of such releases shall not, however, be deemed a prerequisite to the effectiveness of this policy.

Cumulative Effect. Provisions in this Plan and in application forms relating to authorizations, confidentiality of information and immunities and exemptions from liability are in addition to other protections provided by federal and Alaska law, as the same may be amended from time to time and not in limitation thereof.

**ATTACHMENT A**

**APPROVED ALLIED HEALTH PROFESSIONALS  
AND CLINICAL STAFF CATEGORIES AT PAMC**

**ALLIED HEALTH PROFESSIONALS (REQUIRE SUPERVISING PHYSICIAN/MEDICAL DIRECTOR(S))**

Certified Nurse Midwife (CNM)  
Clinical Psychologist  
Advanced Nurse Practitioners (ANP)  
Physician Assistant (PA)

**CLINICAL STAFF REQUIRE EMPLOYMENT BY PHYSICIAN(S) OR CONTRACT WITH PAMC)**

Registered Nurse (RN)  
Surgical Assistant/Dental Assistant  
Pathology Assistant  
Perfusionist