AGENDA
Board of Directors Meeting
6:30 PM - Wednesday, September 24, 2025
Click link to join Zoom meeting
SPH Conference Rooms 1&2
Meeting ID: 878 0782 1015 Pwd: 931197
Phone Line: 669-900-9128 or 301-715-8592

Aaron Weisser, President		Matthew Bullard		Edson Knapp, MD	
Preston Simmons Vice President		Kim Frost		Christopher Landess, MD	
Beth Wythe, Secretary		Michael Dye		Bernadette Wilson	
Walter Partridge, Treasurer					

Board Master Reports List

Mission: South Peninsula Hospital promotes community health and wellness by providing personalized, high quality, locally coordinated healthcare.
Vision: South Peninsula Hospital is the provider of choice with a dynamic team committed to service excellence.
Values: Compassion, Respect, Trust, Teamwork and Commitment

Page

1. CALL TO ORDER

2. ROLL CALL

3. REFLECT ON LIVING OUR VALUES

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

5 4.1. Rules for Participating in a Public Meeting
Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

6. APPROVAL OF THE AGENDA

7. APPROVAL OF THE CONSENT CALENDAR

6 - 10 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for August 27, 2025
08 Board of Directors - Aug 27 2025 - Minutes - DRAFT

11 - 14 7.2. Consideration to Approve August FY2026 Financials
Balance Sheet August FY26
Income Statement August FY26
Cash Flow Statement August FY26

15 - 24 7.3. Consideration to Approve PEN-001 Employee Investment Policy, PEN-002 403b and 457 Plan Investment and F-07 Pension Plan Investment.
PEN-001 Employee Investment Policy
PEN-002 403b and 457 Plan Investments
F-07 Pension Plan Investment

25 - 26 7.4. Consideration to Approve Policies SM-11 Employee Recognition and SM-12 Board Member Stipends with No Changes as Recommended by the Governance Committee
SM-11
SM-12

7.5. Consideration to Approve a Proclamation for Fidoysia Reutov on her Retirement after 23 Years at South Peninsula Hospital

8. PRESENTATIONS

8.1. Presentation of a Proclamation to Fidoysia Reutov on her Retirement after 23 Years at South Peninsula Hospital

9. UNFINISHED BUSINESS

10. NEW BUSINESS

27 - 113 10.1. Consideration to Approve the revised Medical Staff Bylaws, as amended by the SPH Medical Staff
Memo
SPH Medical Staff Bylaws, revised 09 2025

114 - 128 10.2. FIRST READING of an Amendment to the SPH Board of Directors Bylaws to Remove the Reference to Robert's Rules and Replace with Succinct Meeting Rules that Reflect Current Practice *(no action required)*
Memo
25 09 18 BOD Bylaws, with Roberts Rules amendment

11. REPORTS

129 - 133 11.1. Chief Executive Officer
Q4-FY25 Balanced Scorecard

11.2. BOD Committee: Finance & Pension

11.3. BOD Committee: Strategic Planning & Communication

134 - 138 11.4. BOD Committee: Governance
SM-09 Draft
SM-10 Draft
New Policy: Investigation of CEO Misconduct

139 11.5. BOD Committee: Quality
FY 2026 Quality Committee Calendar

11.6. Chief of Staff

11.7. Service Area Board Representative

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

14.2. Board Members

15. INFORMATIONAL ITEMS

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Consideration to Approve Resolution 2025-21, Approving the Medical Staff Credentialing for September, 2025

18. ADJOURNMENT

South Peninsula Hospital

MEMO

Administration
4300 Bartlett Street
Homer, AK 99603
907-235-0325 ~ 907-235-0253, fax

To: Public Participants

From: Operating Board of Directors – South Peninsula Hospital

Re: Rules for Participating in a Public Meeting

The following has been adapted from the "Rules for Participating in a Public Meeting" used by Kenai Peninsula SAB of SPHI and reflects language from the Operating Agreement with the Kenai Peninsula Borough.

Each member of the public desiring to comment upon policies or proposed actions of the SPH Operating Board of Directors at tonight's meeting will be given an opportunity to speak within the following guidelines:

- *Comments are restricted to policies or proposed actions of the SPH Operating Board of Directors.*
- *Those who wish to speak will need to sign in on the sign in sheet being circulated. When the chair recognizes you to speak, you need to clearly give your name and the policy or proposed action you wish to address.*
- *Please be concise and courteous. There is a limit of 3 minutes per speaker; total time allotted for public comment is at the discretion of the chair.*
- *Please observe normal rules of decorum and avoid disparaging by name the reputation or character of any member of the Operating Board of directors, the administration or personnel of SPHI, or the public. You cannot mention or use names of individuals.*
- *The Operating Board Directors may ask you to respond to their questions following your comments. You could be asked to give further testimony in "Executive Session" if your comments are directly related to a member of personnel, or management of SPHI, or dealing with specific financial matters, either of which could be damaging to the character of an individual or the financial health of SPHI, however, you are under no obligation to answer any question put to you by the Operating Board Directors.*
- *If you have questions, you may direct them to the chair. Questions will not be addressed by the board during the public comment period, but may be addressed at a later time.*

These rules for participating in a public meeting were discussed and approved at the Board of Directors meeting on September 25, 2024.

MINUTES

Board of Directors Meeting

6:30 PM - Wednesday, August 27, 2025

Conference Rooms 1&2 and Zoom

The meeting of the Board of Directors of South Peninsula Hospital was called to order on Wednesday, August 27, 2025, at 6:30 PM, in the Conference Rooms 1&2 and Zoom.

1. CALL TO ORDER

President Aaron Weisser called the regular meeting to order at 5:30pm.

2. ROLL CALL

BOARD PRESENT: **Aaron Weisser, Edson Knapp, Walter Partridge, Michael Dye, Bernadette Wilson, Beth Wythe, Preston Simmons, Matthew Bullard, Christopher Landess, Kim Frost, and CEO Ryan Smith**

BOARD EXCUSED:

ALSO PRESENT: **Ryan Smith, CEO; Anna Hermanson, CFO; Amber Gall, CNO, Maura Gibson (Exec Asst.)**

Only meeting participants who comment, give report or give presentations are noted in the minutes. Others may be present.

2.1. A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Amber Gall, CNO, told a Living Our Values story. She read a letter from an appreciative patient.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

4.1. Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience.

6. APPROVAL OF THE AGENDA

6.1.

Beth Wythe made a motion to approve the agenda as presented. Michael Dye seconded the motion. Motion Carried.

7. APPROVAL OF THE CONSENT CALENDAR

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7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for July 30, 2025

7.2. Consideration to Approve July FY26 Financials

Ms. Wythe read the consent calendar into the record.

Beth Wythe made a motion to approve the consent calendar as read. Preston Simmons seconded the motion. Motion Carried.

8. PRESENTATIONS

There was no presentation.

9. UNFINISHED BUSINESS

There was no unfinished business.

10. NEW BUSINESS

10.1. Consideration to Approve SPH Resolution 2025-19, A Resolution of the South Peninsula Hospital Board of Directors Approving a Plan Amendment for the Union and Non-Union 403(b) Plans to Adjust the Annual Employer Match Allowing for End of Year Match True Up Contributions

Anna Hermanson, CFO, reported. The hospital has two 403b plans where the employer matches contributions per paycheck, however some employees frontload their contributions, in which case they don't get their full employer match. This resolution allows for a true up to ensure all employees get an equal match.

Michael Dye made a motion to approve SPH Resolution 2025-19, A Resolution of the South Peninsula Hospital Board of Directors Approving a Plan Amendment for the Union and Non-Union 403(b) Plans to Adjust the Annual Employer Match Allowing for End of Year Match True Up Contributions. A roll call vote was held. Those board members who are employed by the hospital, or have family members employed by the hospital, were recused.

Matthew Bullard - Yes
Michael Dye - Yes
Kim Frost - Yes
Edson Knapp - Recused
Christopher Landess - Recused
Walter Partridge - Yes
Preston Simmons - Yes
Bernadette Wilson - Yes
Beth Wythe - Recused
Aaron Weisser - Recused Preston Simmons seconded the motion. Motion Carried.

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11. REPORTS

11.1. Chief Executive Officer

Ryan Smith, CEO, reported. He spoke about the recent transition to Epic, and how much preparation, work and patience it took from all employees and leaders. He shared that the recent SPH Foundation retreat went well and came with an action plan. The KPB property purchases on behalf of the hospital have gone to the assembly for vote. Mr. Weisser noted that although one of the properties is the slope behind the hospital, there is no plan to build on that property.

11.2. BOD Committee: Finance & Pension

Walter Partridge, Committee Chair, reported. The committee met last week to review both Pension and Finance. They reviewed the resolution on tonight's agenda, as well as the standing pension reports. There were no recommendations to change any funds. The LDI is working appropriately. The committee also reviewed the financial reports for July. Ms. Hermanson shared that there are two new lines on the balance sheet, regarding how we account for the new GASB rules on PTO and Sick Leave.

11.3. BOD Committee: Strategic Planning & Communication

Aaron Weisser, Committee Chair, reported. The committee is working on a handful of things that aren’t quite ready for approval yet. We are hopeful to have a clear, concise strategic plan to support the growth of this hospital. In the next few months we’ll be finalizing the strategic plan and adding the community communication plan.

11.4. BOD Committee: Governance

Beth Wythe, Committee Chair, reported. The Governance Committee continues to work on reviewing the bylaws. They are also working on new member recruitment, with Matthew Hambrick's departure leaving a vacancy, and Walter Partridge has decided to step down at the end of his term. We will be advertising for the open seat, and particularly looking for candidates to represent parts of the hospital's service area outside of Homer, like Anchor Point or Ninilchik.

11.5. BOD Committee: Quality

Preston Simmons, Committee Chair, reported. The committee set a safety topic for generative discussion at the September meeting. Mr. Simmons asked the board to send him any suggestions for topics they'd like to see covered in the future. The committee had a presentation by Rachael Kincaid, COO, on medication administration and storage, as well as a discussion on Patient and Family Advisory Councils. They reviewed near misses and serious safety events. The committee will now work on a plan for the coming year.

11.6. Chief of Staff

Dr. Sarah Roberts, Chief of Staff, reported. The medical staff has been working their way through the Epic transition. It's a rolling process, since the hospital has many visiting providers, and not everyone was present during the training

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and Go-live. She shared a story of Epic allowing her to help a patient with care coordination with providers in another state.

11.7. Service Area Board Representative

Francie Roberts reported on behalf of the Service Area Board (SAB). The SAB met on August 19th and welcomed new member Erin Workman. They approved the resolution regarding the property purchases on behalf of the hospital.

12. DISCUSSION

There were no discussion items.

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience.

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

There were no additional comments from the CEO.

14.2. Board Members

Mike Dye thanked the Strategic Planning Committee for their work on a succinct document. Kim Frost congratulated the hospital staff on a successful transition to Epic. Dr. Knapp thanked everyone for their hard work on the Epic transition, particularly Tiffany Park, Travis Ogden and the radiology team. Christopher Landess echoed the appreciation for the Epic transition. He thanked everyone for the preparation and support for the medical staff. Bernadette Wilson thanked the staff for moving to Epic, and expressed appreciation on behalf of patients. Mary Wythe and Preston Simmons echoed the sentiments about the Epic transition. Aaron Weisser thanked Derotha Ferraro and the marketing team for the excellent social media posts, sharing the great work being done at the hospital with the community.

15. INFORMATIONAL ITEMS

15.1. NRHA Rural Hospital Board of Trustees Certification Program

The National Rural Hospital Association's Board of Trustees Certification Program will be starting a new cohort in October.

15.2. AHA Live Q&A Call with Governance Expert Jamie Orlikoff Tuesday, September 30, 2025 at 9:00am

15.3. Board Agenda Calendar

16. ACTION ITEMS FROM TODAY'S MEETING

17. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

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The board adjourned to executive session at 6:40pm. The board moved back into open session at 7:31pm.

18. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

18.1. Consideration to Approve Resolution 2025-20, Approving the Medical Staff Credentialing for August 2025

Beth Wythe made a motion to approve Resolution 2025-20, Approving the Medical Staff Credentialing for August 2025, to include:

The initial appointment of:

Ed Gonzalez, FNP	*Family/Emergency Med*	*Courtesy*
Joshua Kirbens, MD	*Radiology*	*Courtesy-RCI*
Teresa Kirchner, FNP	*Family Medicine*	*Active*
Dietra Savage, PMHNP	*Psychiatry*	*Courtesy*
James Jordan, MD	*Neurology*	*TeleStroke-Prov*

And the reappointment of:

William Bell, MD	*Family Medicine*	*Active*
Axia Espinosa Morales, MD	*Neurology*	*TeleStroke-Prov*
Larry Kessler, MD	*Radiology*	*TeleRad-vRad*
Pawani Sachar, MD	*Neurology*	*TeleStroke-Prov*
Claudia Thomas, MD	*Orthopedics*	*Courtesy*
Hanbing Wang, MD	*Neurology*	*TeleStroke-Prov*
John Wuellner, MD	*Orthopedics*	*Courtesy*
Albert Ybasco, MD	*Radiology*	*TeleRad-vRad*

And the granting of Epidural steroid injections and Radiofrequency ablation privileges to Dr. Gregory Aird.

Christopher Landess seconded the motion. Motion Carried.

19. ADJOURNMENT

The meeting adjourned at 7:32pm.

Respectfully Submitted,

Maura Jones, Executive Assistant

Accepted:

Aaron Weisser, President

Minutes Approved:

Mary E. Wythe, Secretary

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South Peninsula Hospital

DRAFT-UNAUDITED

BALANCE SHEET
As of August 31, 2025

		As of August 31, 2025	As of August 31, 2024	As of July 31, 2025	CHANGE FROM August, 2024
	ASSETS				
	CURRENT ASSETS:				
1	CASH AND CASH EQUIVALENTS	32,397,421	25,607,496	30,588,821	6,789,925
2	EQUITY IN CENTRAL TREASURY	9,351,015	8,386,931	8,291,326	964,084
3	TOTAL CASH	41,748,436	33,994,427	38,880,147	7,754,009
4	PATIENT ACCOUNTS RECEIVABLE	44,959,114	40,968,914	47,522,987	3,990,200
5	LESS: ALLOWANCES & ADJ	(20,455,477)	(18,520,240)	(21,542,680)	(1,935,237)
6	NET PATIENT ACCT RECEIVABLE	24,503,636	22,448,674	25,980,307	2,054,962
7	PROPERTY TAXES RECV - KPB	3,338,457	2,866,937	1,792,558	471,520
8	LESS: ALLOW PROP TAX - KPB	(4,165)	(4,165)	(1,662)	(0)
9	NET PROPERTY TAX RECV - KPB	3,334,292	2,862,772	1,790,896	471,520
10	OTHER RECEIVABLES - SPH	378,214	60,604	223,205	317,610
11	INVENTORIES	2,865,776	2,633,632	2,678,271	232,144
12	NET PENSION ASSET- GASB	534,985	3,225,068	534,985	(2,690,083)
13	PREPAID EXPENSES	1,154,363	1,096,827	1,227,495	57,536
14	TOTAL CURRENT ASSETS	74,519,703	66,322,004	71,315,306	8,197,699
	ASSETS WHOSE USE IS LIMITED				
15	PREF UNOBLIGATED	6,339,057	6,926,833	6,257,887	(587,776)
16	PREF OBLIGATED	982,687	1,255,227	1,873,072	(272,540)
17	OTHER RESTRICTED FUNDS	868,263	1,211,387	816,787	(343,124)
		8,190,007	9,393,447	8,947,746	(1,203,440)
	PROPERTY AND EQUIPMENT:				
18	LAND AND LAND IMPROVEMENTS	4,345,607	4,124,558	4,345,607	221,049
19	BUILDINGS	68,571,402	67,085,718	66,745,020	1,485,684
20	EQUIPMENT	33,352,847	30,187,936	28,296,243	3,164,911
21	BUILDINGS INTANGIBLE ASSETS	4,257,905	4,028,135	4,257,905	229,770
22	EQUIPMENT INTANGIBLE ASSETS	1,750,896	1,207,638	1,750,896	543,258
23	SOFTWARE INTANGIBLE ASSETS	890,141	2,135,559	890,141	(1,245,418)
24	IMPROVEMENTS OTHER THAN BUILDINGS	1,544,013	926,889	1,449,244	617,124
25	CONSTRUCTION IN PROGRESS	3,650,692	2,540,567	9,406,028	1,110,125
26	LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(62,792,460)	(62,502,125)	(62,648,327)	(290,335)
27	LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(3,023,034)	(3,290,622)	(2,933,228)	267,588
28	NET CAPITAL ASSETS	52,548,007	46,444,253	51,559,529	6,103,754
29	GOODWILL	0	0	0	0
30	**TOTAL ASSETS**	135,257,717	122,159,704	131,822,580	13,098,013
	DEFERRED OUTFLOWS OF RESOURCES				
31	PENSION RELATED (GASB 68)	5,315,248	4,998,234	5,637,473	317,014
32	UNAMORTIZED DEFERRED CHARGE ON REFUNDING	152,615	213,661	157,702	(61,046)
33	TOTAL DEFERRED OUTFLOWS OF RESOURCES	5,467,863	5,211,895	5,795,175	255,968
34	TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	140,725,580	127,371,599	137,617,755	13,353,981

		As of August 31, 2025	As of August 31, 2024	As of July 31, 2025	CHANGE FROM August, 2024
	LIABILITIES & FUND BALANCE				
	CURRENT LIABILITIES:				
35	ACCOUNTS AND CONTRACTS PAYABLE	2,208,368	2,856,728	2,222,877	(648,360)
36	ACCRUED LIABILITIES	11,913,883	11,219,385	8,346,491	694,498
37	DEFERRED CREDITS	841,108	1,193,131	852,218	(352,023)
38	CURRENT PORTION OF LEASE PAYABLE	949,029	186,702	949,029	762,327
39	CURRENT PORTION SOFTWARE INTANGIBLE PAYABLE	199,887	290,358	199,887	(90,471)
40	CURRENT PORTIONS OF NOTES DUE	903,559	45,450	10,587	858,109
41	CURRENT PORTIONS OF BONDS PAYABLE	1,250,000	1,195,000	1,250,000	55,000
42	BOND INTEREST PAYABLE	39,848	31,897	89,167	7,951
43	DUE TO/(FROM) THIRD PARTY PAYERS	1,076,864	877,246	1,176,864	199,618
44	COMPENSATED ABSENCES CURRENT PORTION	5,671,434	0	6,903,679	5,671,434
45	TOTAL CURRENT LIABILITIES	25,053,979	17,895,897	22,000,799	7,158,082
	LONG-TERM LIABILITIES				
46	NOTES PAYABLE	2,940,958	0	3,774,723	2,940,958
47	COMPENSATED ABSENCES NET OF CURRENT PORTION	3,975,093	0	3,035,924	3,975,093
48	BONDS PAYABLE NET OF CURRENT PORTION	4,170,000	5,420,000	4,170,000	(1,250,000)
49	PREMIUM ON BONDS PAYABLE	169,087	256,716	175,064	(87,629)
50	CAPITAL LEASE, NET OF CURRENT PORTION	3,788,440	3,836,628	3,854,661	(48,188)
51	SOFTWARE INTANGIBLE LEASE, NET OF CURRENT PORTION	4,805	202,771	22,791	(197,966)
	TOTAL NONCURRENT LIABILITIES	15,048,382	9,716,115	15,033,163	5,332,267
51					
	TOTAL LIABILITIES	40,102,362	27,612,012	37,033,962	12,490,350
52					
53	DEFERRED INFLOW OF RESOURCES	0	0	0	0
	PROPERTY TAXES RECEIVED IN ADVANCE	0	5	0	(5)
	NET POSITION				
54					
55	INVESTED IN CAPITAL ASSETS	5,731,963	5,731,963	5,731,963	(0)
56	CONTRIBUTED CAPITAL - KPB	0	0	0	0
57	RESTRICTED	25,286	25,286	25,286	0
58	UNRESTRICTED FUND BALANCE - SPH	94,848,502	94,002,333	94,809,077	846,169
59	UNRESTRICTED FUND BALANCE - KPB	17,467	0	17,467	17,467
60	**TOTAL LIAB & FUND BALANCE**	140,725,580	127,371,599	137,617,755	13,353,981

South Peninsula Hospital

INCOME STATEMENT
As of August 31, 2025
DRAFT-UNAUDITED

		MONTH				YEAR TO DATE			
		08/31/25			08/31/24	08/31/25			08/31/24
		Actual	Budget	Var B/(W)	Actual	Actual	Budget	Var B/(W)	Actual
	Patient Service Revenue								
1	Inpatient	3,451,006	3,886,698	-11.21%	3,780,971	6,832,830	7,384,727	-7.47%	6,931,430
2	Outpatient	17,589,344	21,155,570	-16.86%	19,466,078	38,687,938	39,960,520	-3.18%	38,510,881
3	Long Term Care	1,466,248	1,491,919	-1.72%	1,345,209	2,958,749	2,983,838	-0.84%	2,551,599
4	Total Patient Services	22,506,598	26,534,187	-15.18%	24,592,258	48,479,517	50,329,085	-3.67%	47,993,910
	Deductions from Revenue								
5	Medicare	4,726,116	4,880,454	3.16%	5,104,237	10,734,119	9,986,628	-7.48%	11,132,953
6	Medicaid	2,703,948	2,692,776	-0.41%	2,804,057	5,704,426	5,510,093	-3.53%	6,112,947
7	Charity Care	434,267	231,725	-87.41%	238,407	901,966	474,167	-90.22%	370,534
8	Commercial and Admin	2,188,090	2,367,977	7.60%	2,006,644	4,678,426	4,845,473	3.45%	4,041,248
9	Bad Debt	577,485	303,220	-90.45%	311,857	1,057,712	620,464	-70.47%	366,609
10	Total Deductions	10,629,906	10,476,152	-1.47%	10,465,202	23,076,649	21,436,825	-7.65%	22,024,291
11	Net Patient Services	11,876,692	16,058,035	-26.04%	14,127,056	25,402,868	28,892,260	-12.08%	25,969,619
12	USAC and Other Revenue	106,566	131,067	-18.69%	105,926	211,330	262,133	-19.38%	195,044
13	Total Operating Revenues	11,983,258	16,189,102	-25.98%	14,232,982	25,614,198	29,154,393	-12.14%	26,164,663
	Operating Expenses								
14	Salaries and Wages	5,818,834	6,052,647	3.86%	5,472,834	11,772,994	12,105,293	2.75%	10,848,013
15	Employee Benefits	3,159,075	2,979,739	-6.02%	3,035,949	6,705,851	5,593,718	-19.88%	4,720,860
16	Supplies, Drugs and Food	1,359,709	1,863,959	27.05%	1,465,007	3,131,807	3,521,417	11.06%	2,907,628
17	Contract Staffing	454,293	121,180	-274.89%	169,890	935,429	225,080	-315.60%	429,419
18	Professional Fees	732,641	519,726	-40.97%	506,755	1,460,386	974,856	-49.81%	1,074,626
19	Utilities and Telephone	183,555	201,604	8.95%	175,698	370,228	403,209	8.18%	366,732
20	Insurance (gen'l, prof liab, property)	17,933	24,767	27.59%	86,935	36,376	45,996	20.91%	164,722
21	Dues, Books, and Subscriptions	219,625	217,796	-0.84%	18,636	425,720	435,592	2.27%	35,134
22	Software Maint/Support	24,342	85,871	71.65%	186,492	56,061	148,113	62.15%	339,370
23	Travel, Meetings, Education	140,469	181,556	22.63%	42,023	378,002	363,113	-4.10%	78,175
24	Repairs and Maintenance	47,659	58,891	19.07%	136,042	111,075	113,606	2.23%	313,297
25	Leases and Rentals	86,916	99,194	12.38%	105,516	195,363	198,387	1.52%	200,127
26	Other (Recruiting, Advertising, etc.)	171,398	214,901	20.24%	156,465	351,749	429,803	18.16%	338,574
27	Depreciation & Amortization	471,513	565,765	16.66%	431,356	899,691	1,131,531	20.49%	868,116
28	Total Operating Expenses	12,887,962	13,187,596	2.27%	11,989,598	26,830,732	25,689,714	-4.44%	22,684,793
29	**Gain (Loss) from Operations**	**(904,704)**	**3,001,506**	**130.14%**	**2,243,384**	**(1,216,534)**	**3,464,679**	**135.11%**	**3,479,870**
	Non-Operating Revenues								
30	General Property Taxes	403,279	483,783	-16.64%	385,824	1,012,542	1,407,371	-28.05%	1,110,704
31	Investment Income	98,505	132,516	-25.67%	79,871	204,511	265,030	-22.83%	167,563
32	Governmental Subsidies	0	0	0.00%	0	0	0	0.00%	0
33	Other Non Operating Revenue	0	216	100.00%	9,664	3,198	434	100.00%	9,709
34	Gifts & Contributions	0	0	0.00%	0	0	0	0.00%	0
35	Gain <Loss> on Disposal	0	0	0.00%	100	0	0	0.00%	100
36	SPH Auxiliary	679	794	-14.48%	2,142	1,133	1,586	-28.56%	2,737
37	Total Non-Operating Revenues	502,463	617,309	-18.60%	477,601	1,221,384	1,674,421	-27.06%	1,290,813
	Non-Operating Expenses								
38	Insurance	0	0	0.00%	0	0	0	0.00%	0
39	Service Area Board	0	0	0.00%	3,828	0	0	0.00%	3,828
40	Other Direct Expense	656	9,501	93.10%	50,000	1,406	19,000	92.60%	50,000
41	Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42	Interest Expense	49,627	60,785	18.36%	46,686	112,928	121,571	7.11%	93,366
43	Total Non-Operating Expenses	50,283	70,286	28.46%	100,514	114,334	140,571	18.66%	147,194
	Grants								
44	Grant Revenue	32,000	139,880	0.00%	99,676	114,620	279,760	0.00%	152,143
45	Grant Expense	335	15,986	97.90%	0	6,615	31,972	79.31%	54,290
46	Total Non-Operating Gains, net	31,665	123,894	-74.44%	99,676	108,005	247,788	56.41%	97,853
47	Income <Loss> Before Transfers	(420,859)	3,672,423	111.46%	2,720,147	(1,479)	5,246,317	-100.03%	4,721,342
48	Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49	**Net Income**	**(420,859)**	**3,672,423**	**-111.46%**	**2,720,147**	**(1,479)**	**5,246,317**	**-100.03%**	**4,721,342**

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South Peninsula Hospital

Statement of Cash Flows
As of August 31, 2025

	Cash Flow from Operations:		
1	YTD Net Income		(1,479)
2	Add: Depreciation Expense		899,691
3	Adj: Inventory (increase) / decrease		(187,505)
4	Patient Receivable (increase) / decrease		1,476,671
5	Prepaid Expenses (increase) / decrease		73,132
6	Other Current assets (increase) / decrease		(1,698,405)
7	Accounts payable increase / (decrease)		(14,510)
8	Accrued Salaries increase / (decrease)		3,567,392
9	Net Pension Asset (increase) / decrease		-
10	Other current liability increase / (decrease)		(651,214)
11	Net Cash Flow from Operations		3,463,773
	Cash Flow from Investing:		
12	Cash paid for the purchase of property/equip		(511,276)
13	Cash transferred to plant replacement fund		-
14	Proceeds from disposal of equipment		-
15	Net Cash Flow from Investing		(511,276)
	Cash Flow from Financing		
16	Cash (paid) / received for Lease Payable		(84,208)
17	Cash paid for Debt Service		-
18	Net Cash from Financing		(84,208)
19	Net increase in Cash	$	2,868,289
20	Beginning Cash as of July 1, 2025	$	38,880,147
21	Ending Cash as of August 31, 2025	$	41,748,436

PURPOSE:
Guidelines for management of employee pension trust.

DEFINITIONS:
N/A

POLICY:
South Peninsula Hospital sponsors a Defined Benefit Plan for the exclusive benefit of the participants.The name of the plan is The South Peninsula Hospital Employee Pension Plan (Plan). The Plan Trustees shall fulfill their fiduciary responsibility solely for the plan participants and their beneficiaries while controlling administrative costs at a reasonable level. Plan contributions and assets must be sufficient to meet the obligations of the plan as they come due.

INVESTMENT POWERS AND DUTIES OF THE TRUSTEES: Section 7.2 of the South Peninsula Hospital Employee Pension Plan authorizes the Plan Trustees to invest the funds of the plan. This Section of the plan states,

"The Trustee shall invest and reinvest the Trust Fund to keep the Trust Fund invested without distinction between principal and income and in such securities or property, real or personal, wherever situated, as the Trustee shall deem advisable, including, but not limited to, stocks, commonor preferred, bonds and other evidences of indebtedness or ownership, and real estate or any interesttherein. The Trustee shall at all times in making investments of the Trust Fund consider, among otherfactors, the short and long-term financial needs of the Plan on the basis of information furnished by the Employer."

INVESTMENT POLICY:
1. Invest the Plan's assets with the objective to maintain and increase the purchasing power of those assets relative to inflation.
2. Purchase assets of a type and in a manner that a normal investment manager of prudence and caution would purchase. This includes limiting the fees associated with "churning" the investments.
3. Emphasize continuity of performance over volatility and short-term performance.

INVESTMENT GOALS:
1. To attain a rate of return that compares favorably relative to standard market indices over a market cycle
2. To generate sufficient asset growth in real terms to meet future benefit obligations. Asset growthwithin the plan should reduce the long-term capital required from the plan sponsor.
3. Exceed the rate of inflation as measured by the Consumer Price Index by at least 3% per annum.
4. Improve and stabilize the funded status of the Plan. Accordingly, plan assets may be allocated for the purposes of:
5. Achieving a long-term rate of return that exceeds the growth rate of liabilities; and
6. Matching the market value and risk of the Plan's assets with the Plan's liabilities.

INVESTMENT STRATEGY:
Capital preservation and managed risk are an integral part of the hospital's investment strategy. Capital preservation during periods of declining markets should be emphasized versus maximizing performance during expanding market periods. High risks should be avoided, while moderate riskshould be assumed in order to achieve the goals of exceeding inflation.

The primary strategy used to reduce risk and enhance returns is diversification. Diversification in equities is most easily and economically achieved through the use of index mutual funds. The Fund'sinvestments

are spread between three (3) major asset classes:

- Equities
- Fixed Income
- Cash Equivalents

This diversification not only reduces the possibility of major losses but enables the Plan to share inthe gains made in each of the assets' classes.
South Peninsula Hospital will at all times seek to minimize the risk to the Plan by selecting investments and investment strategies that will maintain the plan assets at a level sufficient to cover current and future plan payouts while simultaneously keeping PGBC premiums and monthly cash contributions to the plan at a minimum.

INVESTMENT OBJECTIVES:

1. Fixed Income:
   - The fixed account should provide a competitive return with the lowest level of risk. This can be achieved through a fixed account that guarantees a minimum interest rate and pays currents rates.
   - The Plan shall be allowed to hold fixed-income mutual funds with an average bond qualityof A or better.
2. Cash/Cash Equivalents:
   - Cash equivalent reserves shall consist of cash instruments having a quality rating of A-1, P-1 or higher. Eurodollar certificates of deposit, time deposits, and repurchase agreements are also acceptable investment vehicles.
   - Any idle cash not invested by the investment managers shall be invested daily through an automatic interest-bearing sweep vehicle managed by the custodian.
3. Long Term Objectives – Five Years and Beyond – Equities:
   Index mutual funds shall normally be used to achieve adequate diversification and minimize management costs. If investments are made in equities other than through mutual funds, suchequity investments will be reasonably diversified in the most efficient manner.
   - U.S. Equities:
     a. Equity holdings in any one company should not exceed more than 5% unless the specific stock is equal to more than 5% of its benchmark index of the market value ofthe Plan's equity portfolio.
     b. No more than 25% of the market value of the portfolio shall be invested in any one economic sector.
   - International Equities:
     a. Equity holdings in any one company shall not exceed more than 5% unless the specific stock is equal to more than 5% of its benchmark index of the internationalequity portfolio.
     b. No more than 25% of the portfolio shall be invested in one industry category.
     c. Allocations to any specific country shall not be excessive relative to a broadly diversified international equity manager peer group. It is expected that the non-U.S.equity portfolio will have no more than 40% in any one country.

INVESTMENT GUIDELINES:

1. <u>Allowable Investments</u>
   All or any part of the pension assets may be placed in investment vehicles that are not listed under prohibited transactions. All companies offering investments should have nationally recognized ratings such as Standard & Poor's, A.S. Best, Morningstar, and Duff & Phelps etc.
2. <u>Prohibited Transactions</u>
   There shall be no investments or transactions specifically prohibited by the Employee Retirement Income Security Retirement Act of 1974 or amendments thereto. In addition, investment activity in the following is prohibited without prior written permission of the Board of Directors of the South Peninsula Hospital, Inc.:
   - Stock Options, Futures, or Commodities
   - Coin or Gold Futures
   - Volatile Derivative Investments

- Stock Loans
- Margin Purchase or Borrowing Money
- Direct Ownership of Letter Stock
- Any Municipal or other Tax-Exempt Securities

ELIGIBLE ASSETS:

1. Fixed Income
   - Government & Corporate Bonds

2. U.S. Equities
   - Large Cap
   - Mid Cap
   - Small Cap

3. International Equities
   - Developed Countries / EAFE
   - Emerging Markets

4. Cash & Cash Equivalents

ASSET ALLOCATION:

Allowable Range	Target	Minimum	Maximum
Equities	5%	3%	55%
Large Cap	5%	3%	50%
Mid Cap	0%	0%	25%
Small Cap	0%	0%	25%
International	0%	0%	25%
Fixed Income	95%	45%	97%
Total Return Bond	7%	5%	75%
Short Term Bonds	3%	0%	15%
Long Term Bonds	82%	0%	85%
Cash Alternatives	3%	0%	10%

ASSET REBALANCING:

The Plan's strategic asset allocation will be reviewed annually during the first quarter of the calendaryear, and rebalanced if any of the asset classes vary as much as plus or minus 10 percent, depending on market conditions.

Each year the Plan's trustees will meet to discuss the asset allocation to determine how much of thefund to invest in fixed income, U.S., and international equities. The following factors will be taken intoconsideration:

- The long-term average rate of return being sought
- The amount of risk to which the portfolio should be exposed
- The probability of preserving principal
- The probability of earning enough to offset inflation; and
- The probability of earning, in upcoming years, the target rate of return.

COMMUNICATION AND CONTROL PROCEDURES:

1. Control:
   If an investment manager is used, the duties and responsibilities of each investment managerretained by the Trustees include:
   - Managing the Plan's assets under its care, custody, and/or control in accordance with investment policy goals, objectives and guidelines set forth herein, or expressed in separate written agreements when deviation is deemed prudent and desirable by the Plan.
   - Exercising investment discretion (including holding cash equivalents as an alternative) within the

investment policy goals, objectives and guidelines set forth herein.

- Utilize the same care, skill, prudence, and due diligence under the circumstances then prevailing that experienced investment professionals acting in a like capacity and fully familiar with such matters would use in like activities with like aims in accordance and compliance with all applicable laws, rules and regulations from local, state, federal and international political entities as they pertain to fiduciary duties and responsibilities.
- Acknowledge and agree in writing to their fiduciary responsibility to fully comply with theentire investment policy set forth herein, and as modified in the future.

2. Communications:

If an investment manager is not used, the Plan Administrator will provide quarterly reports tothe Trustees and Board of Directors, South Peninsula Hospital, Inc. on asset allocation percentages, gains or losses, and total account value.

If an investment manager is used, the following specific communications shall be required by the Trustees to monitor the investment activities:

- Promptly informing the Plan in writing regarding all significant and/or material matters and changes pertaining to the investment of Plans' assets, including, but not limited to:
  - Investment Strategy
  - Portfolio structure
  - Tactical approaches
  - Ownership
  - Organizational Structure
  - Financial condition
  - Professional staff
  - Recommendations for guideline changes
  - All legal, material and SEC and other regulatory agency proceedings affecting thefirm
- Quarterly reports will be provided by the investment manager including allocation percentages, growth, and total account value. Information about the funds' holdings shouldalso be provided.
- A semi-annual investment performance report will be provided, with a more comprehensivereview annually, to determine the continued feasibility of achieving the investment goals and objectives and the appropriateness of the Investment Policy. The reports will compare overall investment performance to the appropriate indices.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCES:
N/A

CONTRIBUTOR(S)
Pension Committee; Chief Financial Officer

PURPOSE:
Objectives and guidelines for the Investment Plan established for the sole and exclusive benefit of its participants and beneficiaries to set aside money for retirement.

DEFINITION(S):
N/A

POLICY:
A. By and through the authority granted and delegated by the Board of Directors of South Peninsula Hospital ("the Board") to the Pension/Finance Committee ("the Committee") of the South Peninsula Hospital 403(b) Plan for Non-Union Employees and South Peninsula Hospital 403(b) Plan for Employees ("the Policy"). This policy shall apply to all fiduciaries of the Plan.

B. The Committee is charged by the Operating Board of South Peninsula Hospital, Inc. and delegated with the overall responsibility of managing Plan assets for the sole and exclusive benefit of the participants and beneficiaries (collectively the "Participants") in the Plan, per the Employee Retirement Income Security Act (ERISA) as amended. The general purpose of this Policy is to outline a philosophy and approach to guide and assist the Committee in discharging its fiduciary responsibilities to supervise, monitor and evaluate the Plan's Investment Options as defined herein. Specifically, the Policy is intended to provide:
   1. Investment objectives, guidelines, and procedures for the management of Plan assets, subject to the terms of the Plan documents and ERISA.
   2. Guidance for the Consultant, Investment Managers, and other Retirement Plan Service providers (as defined under "Responsibilities and Delegation of Authority") is discharging their duties to the Plan and the Committee regarding the management of plan assets.
   3. Guidelines for management of the Plan in accordance with fiduciary prudence and due diligence requirements and all applicable laws, rules and regulations that may apply to Plan assets.
   4. An indication of the asset classes and investment styles the Committee has chosen to include as Designated Investment Alternatives for Participants.
   5. A description of the quantitative and qualitative measures that the Committee has chosen, with assistance from the Consultant, to assess Fund Managers.
   6. Participants with the ability to invest in a broad range of Investment Options, to allow them to exercise control and diversify their accounts.

C. The Committee has chosen to comply with ERISA Section 404(c), and its interpretive regulations. These regulations, to the extent that they are met, relieve the Committee of certain fiduciary liabilities, including responsibility for the investment decisions made by Participants to the extent that they exercise meaningful control over their accounts. The Committee is responsible for monitoring overall compliance with the Plan documents and satisfying the requirements of 404(c).

D. The primary investment objective of the Committee, consistent with Section 404(c), is therefore to offer Participants a broad range of diversified Investment Alternatives that are appropriate for the accumulation of retirement income benefits with assets that are subject to participant investment direction.

E. Responsibilities and Delegation of Authority:
   1. The ultimate responsibility for the proper supervision of the Plan's Investment Options and Alternatives will rest with the Committee, with the assistance of advisors and other third parties, as described below:
      a) Committee—The Committee has been delegated by the Board as the Named Fiduciary of the Plan and will have the exclusive authority to establish, execute, interpret, and modify this Policy for the Plan. The Committee shall be solely responsible for the selection and retention of outside professionals to the Plan, which may include, but are not limited to, consultants, investment

managers, plan administrators, record keepers, custodians, trustees, attorneys, accountants, and clerical staff, using any method that the Committee deems to be prudent under the circumstances. The Committee is responsible for reviewing investment objectives, policies and guidelines; reviewing performance of the Investment Options and compliance with the policies; and reporting to the Board or appropriate committee on a regular basis.

b) Consultant—The Consultant assists the Committee in tasks deemed appropriate by the Committee. These duties are separately enumerated in an investment consulting agreement. The Committee intends for the Consultant to serve as a non-discretionary investment manager as set forth and acknowledged in such separate agreement. Any Consultant so engaged shall have demonstrated competencies in understanding and working with the basic tenets of Modern Portfolio Theory, a large and broadly accepted body of empirical and theoretical knowledge about the behavior of capital markets.

c) Investment Managers or Fund Managers (the "Manager")— Investment managers as defined and qualified under ERISA to whom the fiduciaries delegate responsibility for investing and managing plan assets in accordance with applicable law. Managers have discretion to buy, sell or hold securities and to alter asset allocation within the parameters established by law and subject to the fiduciary standards under ERISA and, to the extent consistent with ERISA, the terms of the Investment Company Prospectus, trust documents and investment guidelines of the fund.

d) Plan Administrator—The Plan Administrators are responsible for administrative decisions with regard to the Plan, including for example the calculation of employee eligibility and vesting, facilitating distributions, and carrying out all governmental regulations including required filings and plan notices. The Plan Administrators may function in gathering, collecting, or distributing reports or other information to Participants and to the Committee and other Plan fiduciaries for their review in carrying out their duties. The Plan Administrators, including both internal and independent outside administrative services firms who are not specifically named as fiduciaries are acting solely in a directed capacity, to administer and carry out those functions necessary and deemed prudent by the Committee.

e) Retirement Plan Service Provider (the "RPS Provider")— The RPS Provider may provide various services including, but not limited to, administration, recordkeeping, custody and trustee services, compliance testing and support, employee education and communication, plan sponsor reporting, participant statements and access to Fund Managers.

2. An RPS Provider will be designated and delegated the responsibility to provide educational materials to the Participants on a regular basis, to assist them in understanding the various characteristics of each Investment Alternative available to them under the Plan, and the basic principles of investing, asset allocation and diversification. An RPS Provider will be designated and delegated the responsibility to provide Participants with quarterly information as required under ERISA Section 404a–5, as amended. An RPS Provider will be designated and delegated the responsibility to provide Participants with required QDIA notices in accordance with applicable regulations.
3. Effective communication between the Committee, Investment Managers, Consultants and all other service providers engaged to provide service to the Plan is required. All parties will communicate unusual, notable or extraordinary events to the Committee.
4. Under no circumstances will the performance of the Committee or Consultant's duties pursuant to this Policy be construed as rendering individualized investment advice to a Participant. The Participants have the exclusive responsibility for determining the suitability of any Investment Option offered under the Plan to their individual accounts and are responsible for their decisions to invest in any Investment Option offered under the Plan.

F. Investment Options Under the Plan:

1. It is anticipated that Participants in the Plan will have control and direction of their individual accounts. The Committee recognizes that asset allocation is a key determination of the return, risk, and liquidity characteristics of an investment portfolio. Moreover, the Committee recognizes the Participants may have disparate levels of investment knowledge, experience, and motivation. Therefore, in conjunction with the Consultant, the Committee has determined which broad tiers of Investment Alternatives will be provided to Participants under the Plan and has made available specific Investment Options solely in the interest of Participants. These Investment Options present a broad range of investments, which when combined may diversify portfolios for the benefit of mitigating market risks and may

accommodate the different and unique needs of individual Participants. Moreover, the Committee will review the fees and expenses for each Investment Option and Investment Alternatives to determine reasonableness and may take into account any opportunity to use such fees and expenses to offset Plan recordkeeping, administrative, and other costs.

- Tier 1 – Asset Allocation Portfolios: This Alternative will consist of professional managed portfolios, such as target date funds, applying generally accepted investment theories, and are diversified so as to provide long-term appreciation, capital preservation, and mitigation of large losses. Such Investment Alternatives may be structured to vary based on a participant's age or target date, risk tolerances across a range, or based on the target risk appropriate for Participants as a whole. The Committee will designate a *Qualified Default Investment Alternative (QDIA)* from this Tier as a "default" Investment Alternative for those participants who do not make an investment election for their accounts, and it is intended for the QDIA to satisfy the ERISA Section 404c-5 and regulations issued by the Department of Labor. The Committee has designated a target date series as the Plan's QDIA.
- Tier 2 – Designated Investment Alternatives (DIA): To the extent permitted by the Plan, and to allow Participants to exercise control over the individual investment accounts, the Committee has approved Designated Investment Alternatives as a core menu based on the availability of suitable Fund Managers and which may consist of, but will not be limited to, the determination of their own investor profiles. Participants will be given sufficient information as necessary for them to understand the DIA and to make reasonable, informed investment decisions. The DIA may include a combination of passive/market indexing as well as active managers.

G. The Committee and the Consultant will review this Policy periodically. The Consultant reserves the right to modify the Policy at any time, and from time to time, as it deems necessary and appropriate. Any change to this Policy will be subject to mutual consent of the Committee and the Consultant. Adoption and acknowledgement of this Policy will be notated in the respective Committee meeting minutes for the purposes of documentation and records.

PROCEDURE:

A. Fund Manager Selection and Monitoring

1. All investment decisions will be made informed by the guidelines of quality, marketability and diversification outlined in the Prospectus or other pertinent documents and will be in compliance with any controlling state and/or federal statutes or other guidelines. The Designated Investment Alternatives shall be determined with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and aims.
2. Active Managers:
   In selecting and monitoring Active Managers, the Committee will consider the following criteria:
   a) Quantitative Measures:
      - *Style Consistency* – Does the Manager exhibit consistent style attributes over rolling 36-month periods?
      - *Risk-Adjusted Returns* – On a risk-adjusted basis, has the Manager outperformed its benchmark or peer group over the last 24 months?
      - *Performance Consistency* – Has the Manager outperformed its benchmark or peer group in at least half of the last 24 months? Also known as "batting average", this is an indicator of the consistency of Manager out-performance compared to its benchmark or average peer. A batting average of greater than 0.50 or 50% indicates that the Manager has outperformed its benchmark or peer group in a majority of time periods.
      - *Expense ratio* – Is the annual expense ratio reasonable for its peer group?
   b) Qualitative Measures:
      - *Stability of Management* – Has the current portfolio manager or portfolio management team managed the fund for at least three (3) years? Have any changes occurred to the firm's ownership, control, or management? Is the firm subject to any regulatory action, investigation, or litigation by a government agency?
      - *Consistent Philosophy* – Is the manager continuing to adhere to the stated investment

philosophy and objectives?
- *Investment Process* – Is the manager continuing to successfully follow and implement the stated investment process?

3. Passive (Index) Managers:
In selecting and monitoring Passive (or Index) Manager, the Company will consider the following criteria:
   a) Quantitative Measures:
      - *Tracking* – Does the Manager track within a reasonable range to the benchmark, as measured by tracking error, R-squared, and/or relative return?
      - *Expense Ratio* – Is the Manager's annual expense ratio reasonable for its peer group?
   b) Qualitative Measures:
      - *Investment Process* - Is the Manager continuing to successfully follow and implement the investment process? Is the current Manager efficient at managing cash flows and transaction-related expenses?
4. Target Date Fund Selection:
In selecting the Target Date Fund Series, the Committee will consider the following criteria:
   a) Investment Methodology:
      - *Portfolio Construction* – Are the allocation and the diversification across and within asset classes/investment styles (including nontraditional asset classes) appropriate and consistent with the target date and risk level?
      - *Manager Selection* – Are underlying Managers selected utilizing an objective, best-in-class, clearly defined manager selection and monitoring process, or is there a bias towards proprietary Managers? Insofar as any bias may exist in the selection of underlying managers, what is the quality of the Manager level holdings and are competitive returns achieved across asset classes and styles?
      - *Risk Management* – Are the asset class weightings appropriate given the Manager's target and does an appropriate balance exist between maximizing long-term growth and managing risks?
      - *Glide Path* – Is the glide path appropriate for and consistent with Plan terms?
   b) Organizational Strengths:
      - *Manager Experience* - How long has the firm and Manager been managing asset allocation funds, what are the assets under management and are the resources available sufficient to effectively execute the process?
   c) Expenses
      - *Expenses* – Are the annual expense ratios reasonable given the investment strategy?
   d) Performance
      - *Risk-Adjusted Returns* – Over the past 24 months on average, has the series outperformed the appropriate benchmarks or peer groups on a risk-adjusted basis?
      - *Performance Consistency* – Has the series outperformed the appropriate benchmarks or peer groups in at least half of the last 24 months?
5. Target Date Fund Monitoring:
In monitoring the Target Date Fund Series, the Consultant will consider the following criteria:
   - *Risk-Adjusted Performance for the Most Conservative Fund* – Over the past 60 months on average, has the fund outperformed the appropriate benchmarks or peer groups on a risk-adjusted basis?
   - *Risk-Adjusted Performance for the Most Aggressive Fund* – Over the past 60 months on average, has the fund outperformed the appropriate benchmarks or peer groups on a risk-adjusted basis?
   - *Expenses* – Is the series average annual expense ratio reasonable given the investment strategy? Or are expenses below the median for the peer group?
   - *Risk Management and Glide Path Stability* – Are the asset class weightings appropriate given the Manager's target and does an appropriate balance exist between maximizing long-term growth and managing risk? Have there been any dramatic shifts in the target weightings in recent history?
   - *Manager and Organizational Stability* – Have there been any material changes to the team and its leadership that may adversely impact future competitiveness of the series?

B. Watchlist and Replacement:
To ensure that each Manager continues to meet the criteria, the Consultant will prepare a quarterly report

detailing each Manager's performance within the context of the requirements of this Policy and any other criteria that the Consultant and the Committee deem appropriate.

- *Active Managers & Passive (Index) Managers* – Active Managers who fail to meet two (2) or more of the seven (7) criteria set forth above or Passive (Index) Managers who fail either the Tracking or Investment Process criteria, shall be placed on a Watchlist for monitoring for up to eight (8) quarters. If, during that period, the Manager is not able to bring such variances within guidelines, the Consultant will communicate any deficiencies and remedies to the Committee, as appropriate.
- *Target Date Fund Series* – failing two (2) or more of the five (5) criteria set forth above, or that fail the "Manager and Organizational Stability" criteria shall place the Target Date Fund Series on a Watchlist for monitoring for up to eight (8) quarters. If, during that period, the Manager is not able to bring such variances within guidelines, Consultant will communicate any deficiencies and remedies to the Committee, as appropriate.

C. Investment Manager Reporting and Review:

1. Performance reports will be compiled by the Consultant at least quarterly and communicated to the Committee for review. The investment performance of each Investment Option will be measured against commonly accepted class and style-specific benchmarks and peer group universes as noted in the Policy.
2. The Plan Consultant may make recommendations after considering the criteria set forth in section B, to replace individual investment offerings or funds which are underperforming compared to its peer group or Index. That recommendation will be reported to the Committee.
3. Committee will review recommendations of the Consultant and Plan Administrator and approve or deny Investment Option changes by a roll call vote.
4. Committee meetings will be scheduled on a regular basis, but may meet more or less frequently in its discretion if circumstances warrant, to review and discuss:
   - Any significant changes with any Plan Service Providers or Managers
   - Important developments within the economy and the securities markets, and their potential effect on Plan investments and assets
   - Each Manager's net investment performance, risk and style characteristics relative to the stated policies and objectives and according to the selection and evaluation criteria contained within this Policy
   - Plan and Manager fees and expenses to evaluate reasonableness and necessity
   - Exceptions or changes to this Policy

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
N/A

CONTRIBUTOR(S):
Board of Directors Finance/Pension Committee

South Peninsula Hospital	**SUBJECT:** Pension Plan Investment	**POLICY #:** F-07 **Page 1** of **1**
Scope: Finance **Approved by:** Board of Directors		**Original Date:** 10/22/03 **Effective:** ~~3/27/24~~9/24/25
Revised: 8/28/19; 9/24/25 **Reviewed:** 3/27/24		**Revision Responsibility:** Board of Directors

PURPOSE:
Guidelines for the management of the South Peninsula Hospital (SPH) Employee's Pension Plan (Plan).

DEFINITION(S):
N/A

POLICY:
A. The ~~Trustees of the SPH Plan~~ SPH Board Finance and Pension Committee shall establish a policy for the investment of Plan assets that provide guidelines to meet the fiduciary responsibilities of the hospital and ensure adequate funding of the Plan for employees and other beneficiaries.
B. A report of fund activity will be made to the Board no later than the end of the first quarter of each calendar year.
C. The investment policy for the Plan will be maintained with the Plan description and documents. The ~~Plan Trustee~~Finance and Pension Committees~~s~~ will review the investment policy at least every two years and report the results of the review to the Board.
D. The Plan will be audited annually, and a report of the audit results will be made to the Board.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
N/A

CONTRIBUTORS:
Chief Financial Officer; Board of Directors

South Peninsula Hospital	**SUBJECT:** Employee Recognition	**POLICY #:** SM-11 **Page 1** of **1**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** 12/17/08 **Effective:** ~~1/24/24~~9/24/25
Revised: 9/24/08, 9/24/14, 11/17/15, 4/28/21 **Reviewed:** 9/24/25~~1/24/24~~		**Revision Responsibility:** Board of Directors

PURPOSE:
Program guidelines for the recognition of employees based on years of service.

DEFINITION(S):
N/A

POLICY:
A. The Board of Directors recognizes years of service of employees of South Peninsula Hospital (SPH) and observes the following program of recognition
   1. The Board of Directors will present retiring Employees who have completed 20 or more years of service to SPH a Proclamation recognizing their contribution.
   2. Administration will notify the President of upcoming retirement plans for placement of the Proclamation on the Consent Agenda for the President's signature.
   3. Administration will prepare the Proclamation for presentation to the employee.
   4. If insufficient time is available for the Proclamation to be placed on the Consent Agenda, this policy authorizes an officer of the Board to sign the Proclamation without the vote of the Board. In such an event, notice of such will be provided at the next board meeting.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
1. South Peninsula Hospital's Values & Behaviors as adopted by the Board of Directors

CONTRIBUTORS:
~~Operating Board Members~~Board of Directors; Human Resources Director

South Peninsula Hospital	**SUBJECT:** Board Member Stipends	**POLICY #:** SM-12 **Page 1** of **1**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** 3/29/18 **Effective:** ~~1/24/24~~9/24/25
Revised: 8/28/19 **Reviewed:** 9/24/25		**Revision Responsibility:** Board of Directors

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PURPOSE:
Guidelines for remuneration to the Board of Directors for their services as members.

DEFINITION(S):
N/A

POLICY:
A. The Board of Directors will receive a stipend based on the following schedule effective January 1, 2018:

Position	Monthly Stipend
Director	$500
Officers:	
Treasurer	$625
Secretary	$625
Vice President	$625
President	$750

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
N/A

CONTRIBUTOR(S):
Board of Directors; Chief Financial Officer

Medical Staff Office
4300 Bartlett Street
Homer, AK 99603
(907) 235-0849
medstaffoffice@sphosp.org

MEMO

To: South Peninsula Hospital Board of Directors

From: Medical Staff Office

Date: September 15, 2025

Re: South Peninsula Hospital and Long Term Care Facility – Medical Staff Bylaws

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Dr. Paul Murphree of Chartis/Greeley assisted the medical staff leadership with review and revision of the Medical Staff Bylaws, which had not undergone comprehensive review since 2021. Dr. Murphree visited SPH to assist with this process, and attended a Medical Executive Committee (MEC) meeting to help present the revisions and answer any questions. On July 9, 2025 the South Peninsula Hospital MEC approved the revised draft of the South Peninsula Hospital and Long Term Care Facility – Medical Staff Bylaws.

On August 9th, 2025 the revised draft was presented to the full medical staff via email, soliciting feedback. Multiple members offered suggestions and questions. Edits were made, vetted by Dr. Murphree, and the final version was approved by the MEC on September 5, 2025.

At the General Medical Staff meeting on September 10, 2025 the membership as a whole voted in favor of the revised South Peninsula Hospital and Long Term Care Facility – Medical Staff Bylaws by a 2/3 supermajority.

Per the Medical Staff Bylaws, Section 9. Review, Revision, Adoption and Amendment

9.2.3 Approval Process.

a. The bylaws amendment will be voted on at a general Medical Staff meeting. For approval, there must be a two-thirds (2/3rds) supermajority vote of the votes cast, when a quorum is present.

b. Amendments so adopted shall be effective when approved by the Board.

Below is a Summary of Change for South Peninsula Hospital Bylaws:

4/29/2025, 5/23/25, 6/5/25, 8/9/25, 9/4/25

Note: Minor edits for clarity, spelling, punctuation, etc. are not specifically addressed here.

The items in red were added due to feedback provided by the Medical Staff and not included in the original draft of this document.

Part I: Governance

Added Definitions for CMO, COO, Corrective Actions, Investigation, Privileges, and MEC

2.6.4: Clarifying that the Chief Medical Officer (CMO) role is an Administrative leader and not a Medical Staff leader

2.6.6 Reporting a newly filed malpractice claim. Added : "in writing"

3.1: These categories are "membership" categories

3.1.1: Membership categories: Updated

4.2.2 Add SPH Board to list of exclusions for being an officer of the Medical Staff

4.3: Minor wording changes and added "electronic" means of voting & generalized rank choice voting.

4.4 Term limits for each MEC position, except Peer Review Committee representative.

4.6: Add that vacancies other than Chief of Staff (COS) will follow the same election process as per section 4.3.

4.7: Adding process when COS has a conflict of interest.

6.2: Add CNO, CMO, COO, and CFO as ex officio/non-voting members of MEC.

6.2.1.b Clarified composition of MEC to align with the BOD Bylaws.

7.1 Adding specifics to the described process of notification.

7.4.3: PRC : Adding quorum definition that allows non-final determinations to still be reviewed if at minimum 2 members are present

7.7: Robert's Rules of Order is fine, but realize that only occurs if the Chair decides it is needed.

Part II: Investigations, CA, Hearing, etc.

3.1.13: indented this item to align with "automatic" actions. This section allows the MEC to discuss the automatic action and "Add" to the automatic action another recommendation. For example, someone didn't participate in a mandatory influenza vaccine and furthermore started on a public campaign to stop all influenza vaccine. You might consider additional actions based on their unscientific approach to vaccinations.

7.7 removing clinical psychologist and making this section more "generic"

Part III Credentials

2.2 Add NBPAS as a recredentialing board.

2.2.13 removed since you don't have clinical psychologist now.

2.4 Added qualifications for membership w/o Privileges

4.2.1 & 4.2.2e removed CME tracking & verification

5.6.1 updated APP Students, Residents or fellows in Training language

5.8 added the Credentials Chair to the list of those who must provide recommendations for temp privileges

Organization and Functions Manual

1.3.2 Replace w/Peer Review Policy.

2.4 Remove details regarding composition of the Peer Review Committee and refer to policy. This allows for easier adjustment to the structure of the Peer Review Committee.

3.3.1 define an "Expedited Credentialing Process" that can reduce the need for "Temporary Privileges" It requires 2 board members to approve a Category 1 after MEC recommendation and Credentialing Chair (on the MEC).

South Peninsula Hospital and Long Term Care Facility

MEDICAL STAFF BYLAWS

Part I: Governance

Date

Table of Contents

Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at South Peninsula Hospital (SPH) in order to carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the hospital Operating Board of Directors.

1.2 Authority

Subject to the authority and approval of the Operating Board of Directors the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and associated rules, regulations, and policies and under the corporate bylaws of the South Peninsula Hospital. Henceforth, whenever the term "the hospital" is used, it shall mean South Peninsula Hospital; and whenever the term "the Board" is used, it shall mean Operating Board of Directors. Whenever the term "CEO" is used, it shall mean the Hospital CEO appointed by the Board to act on its behalf in the overall management of the hospital. The term "CEO" includes a duly appointed acting administrator serving when the CEO is away from the hospital.

1.3 Definitions

"Advanced Practice Professional or APP" means those individuals eligible for privileges and membership who are physician assistants (PAs), or advance practice registered nurses (APRNs) such as nurse midwives, certified registered nurse anesthetists (CRNAs), clinical nurse specialists, or nurse practitioners. All APPs with Inpatient privileges shall have a collaborative or supervisory practice agreement with a physician who is privileged on the South Peninsula Hospital Medical Staff.

"Application" means an application for appointment and/or privileges to the Medical Staff as described in Part III, Section 3 of the *Medical Staff Bylaws.*

"Appointee" means any medical or osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, or Advanced Practice Professional holding a current license to practice within the scope of his or her license who is a Member of the Medical Staff.

"Chief Executive Officer" or "CEO" is the individual appointed by the Operating Board of Directors to serve as the Board's representative in the overall administration of the Hospital. The CEO may, consistent with his or her authority granted by the Hospital Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

"Chief Medical Officer" or "CMO" is the individual employed by the Hospital overseeing quality, safety, and medical staff operations.

"Chief Operating Officer" or "COO" is an individual employed to support the CEO in daily operational workings of the organization not specifically delegated to another individual (e.g. Medical Staff operations for the CMO).

"Clinical Privileges" or "Privileges" mean the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental or surgical services with the Hospital.

"Corrective Action" shall mean a restriction, reduction, revocation, or denial of privileges or reduction of membership through automatic/administrative means or that are based on professional review of competency and/or conduct.

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"Days" shall mean calendar days unless otherwise stipulated in the *Medical Staff Bylaws.*

"Dentist" means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in Alaska.

"Good Standing" means having no adverse actions, limitations, or restriction on privileges or medical staff membership at the time of inquiry based on a reason of competence or conduct.

"Operating Board of Directors" or "Operating Board" means the Operating Board of Directors of South Peninsula Hospital.

"Hearing Panel" means the committee appointed to conduct an evidentiary hearing pursuant to a request properly filed and pursued by a Practitioner in accordance with Part II, Section 5 of these *Medical Staff Bylaws.*

"Hospital" means South Peninsula Hospital (SPH) and any SPH Provider Based Clinics.

"Hospital Bylaws" mean those Bylaws established by the Operating Board of Directors.

"Investigation" shall mean a professional review that does or is possible to result in a corrective action and starts upon inquiry and continues through final determination regarding clinical privilege action.

"Medical Executive Committee" shall mean the Executive Committee of the Medical Staff provided for in Part I, Section 6 of the *Medical Staff Bylaws*

"Medical Staff or "Staff" means an individual who is either a medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist or Advanced Practice Professional who has obtained membership status and/or have been granted privileges that allow them to attend patients and/or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

"Medical Staff Bylaws" means these Bylaws covering the operations of the Medical Staff of South Peninsula Hospital.

"Medical Staff Rules and Regulations" means the rules and regulations adopted by the Medical Executive Committee and approved by the Board.

"Medical Staff Year" is defined as the 12-month time period beginning on January 1 of each year and ending December 31.

"Member" is a physician, dentist, oral and maxillofacial surgeon, podiatrist, or Advanced Practice Professional who has been granted this status by the Operating Board of Directors of South Peninsula Hospital.

"Ongoing Professional Practice Evaluation (OPPE)" is a continuous process monitoring a practitioners performance, competency and behavior over time to ensure quality and safety of patient care.

"Oral and Maxillofacial Surgeon" means a licensed dentist with advanced training qualifying them for board certification by the American Board of Oral and Maxillofacial Surgery. The term "dentist" as used in these Bylaws includes oral surgeons.

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"Physician" means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in the State of Alaska.

"Podiatrist" means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in Alaska.

"Practitioner" means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, Advanced Practice Professional, may be granted clinical privileges.

"Prerogative" means the right to participate, by virtue of Staff category or otherwise, granted to a practitioner, and subject to the ultimate authority of the Board and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

"Privileges" means specific right to treat patients within the bounds of medical level diagnostic and therapies as specified by the "Delineation of Privileges" granted to a specific practitioner by the Board.

"Representative" or "Hospital Representative" means the Operating Board of Directors and any trustee or committee thereof; the Hospital CEO or his or her designee; other employees of the Hospital; a Medical Staff organization or any member, officer, clinical Division or committee thereof; and any individual appointed or authorized by any of the foregoing Representatives to perform specific functions related to gathering, analysis, use of dissemination of information.

"Special Notice" means written notice sent via certified mail or e-mail, return receipt requested or by hand delivery evidenced by a receipt signed by the Practitioner to whom it is directed or by the person delivering the notice.

"Written" means documented through entry in an electronic format or on paper.

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Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of the hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, podiatrists, and APPs who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated rules, regulations, policies, and procedures of the Medical Staff and the hospital.

2.2 Qualifications for Membership

The qualifications for Medical Staff membership are delineated in Part III of these bylaws (Credentials Procedures Manual).

2.3 Nondiscrimination

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, color, sex, sexual orientation, gender identification, religion, age, marital status, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC) except for temporary, emergency and disaster privileges. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

Requests for Medical Staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures Manual) of these bylaws.

2.6 Practitioner Responsibilities

2.6.1 Each staff member with privileges must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.

2.6.2 Each staff member and practitioner with privileges must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

2.6.3 Each staff member, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board and documented in the rules and regulations, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

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2.6.4 Each staff member and practitioner with privileges must submit to any pertinent type of health evaluation as requested by one (1) Medical Staff leader (such as a Medical Staff Officer, in conjunction with one (1) administrator (such as a Medical Director, CMO, CEO or their designee) when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the member's or practitioner's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing physician health or impairment.

2.6.5 Each staff member and practitioner with privileges must abide by the Medical Staff bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Hospital.

2.6.6 Each staff member and practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount, sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and practitioner with privileges shall notify the CEO, designee, and MSO in writing immediately of any and all malpractice claims filed in any court of law against the Medical Staff member.

2.6.7 Each applicant for privileges or staff member or practitioner with privileges agrees to release from any liability, to the fullest extent permitted by law, all persons acting in good faith and without malice for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Medical Staff member and his/ her credentials.

2.6.8 Each staff member and practitioner with privileges shall prepare and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.

a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed practitioner with privileges, in accordance with State law and hospital policy.

b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed practitioner with privileges, in accordance with State law and hospital policy.

c. The content of complete and focused history and physical examinations is delineated in the rules and regulations.

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2.6.9 Each staff member and practitioner with privileges will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.

2.6.10 Each staff member and practitioner with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member's clinical privileges.

2.6.11 Each staff member and practitioner with privileges must abide by the Code of Ethics of their profession.

2.6.12 Each Medical Staff leader shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or hospital. Medical Staff leadership will deal with conflict of interest issues per the Conflict of Interest policy.

2.7 Medical Staff Member Rights

2.7.1 Each staff member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Medical Director or appropriate Medical Staff leader(s), that practitioner may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.7.2 Each staff member in the Active category has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Section 4.7 of these bylaws, regarding removal and resignation from office.

2.7.3 Each staff member in the Active category may initiate a call for a general staff meeting, to be held within thirty (30) days, to discuss a matter relevant to the Medical Staff by presenting a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.7.4 Each staff member in the Active category may challenge any rule, regulation, or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.

2.7.5 The above Sections 2.7.1 to 2.7.4 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7.6 Any practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these bylaws).

2.8 Staff Dues

Annual Medical Staff dues, if any, shall be determined by the MEC. Failure of a Medical Staff member to pay dues shall be considered a voluntary resignation from the Medical Staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

2.9 Indemnification

2.9.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and Medical Staff.

2.9.2 Subject to applicable law, the hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a Medical Staff member in connection with the defense of any pending or threatened action, suit, or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or Medical Staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

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Section 3. Categories of the Medical Staff

3.1 The Active Membership Category

Qualifications : Members of this category must maintain an active practice, onsite at least quarterly or greater than 50% of their total practice, located within the South Peninsula Hospital Service Area.

a. As a part of this practice, the practitioner may be involved in admissions, surgeries, consultations, and other patient-facing care services appropriate to the member's specialty; and
b. Hold privileges at SPH within their field of practice; excluding Community Privileges, and;
c. Maintain current licensure, adequate experience, education and training, current professional competence, good judgment, to demonstrate to the satisfaction of the MEC they are professionally proficient and that patients treated by them can expect to receive quality medical care.

3.1.2 Prerogatives

Members of this category may:

a. Vote on all matters presented to the Medical Staff and committee(s) to which the member is assigned; and
b. Hold MEC office. Sit on, or chair any committee in accordance with any qualifying criteria set forth in the Medical Staff bylaws or Medical Staff policies; and
c. Attend, and participate in professional and educational opportunities of the medical staff sponsored by SPH; and
d. Participate in decision making on behalf of the General Medical Staff, MEC, hospital leadership and operational board.

3.1.3 Responsibilities

Members of this category shall:

a. Adhere to the hospital's Medical Staff Bylaws, Rules and Regulations, and Policies as well as state and federal laws and regulations; and
b. Contribute to the organizational and administrative affairs of the Medical Staff;
c. Participate in performance improvement activities, quality assurance and quality improvement activities;
d. Maintain professional standards of conduct, ethics and integrity;

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3.2 The Part-Time Active Membership Category

Qualifications : The Part-Time Active category is reserved for Medical Staff members who may not meet the eligibility requirements for the Active category.

a. Practitioners who provide health and educational services, clinics or consultations within the South Peninsula Hospital Service Area in person or via telehealth to the residents of the Southern Kenai Peninsula. This includes, but is not limited to, practitioners who are employed by SPH in a temporary capacity, on an occasional or intermittent basis or under contract including locum tenens; and

b. Hold privileges at SPH within their field of practice; and have the desire to remain affiliated with the hospital for consultations, call, referrals and/or to utilize SPH services; and

c. Maintain current licensure, adequate experience, education and training, current professional competence, good judgment, to demonstrate to the satisfaction of the MEC they are professionally proficient and that patients treated by them can expect to receive quality medical care.

3.2.1 Prerogatives

Members of this category may:

a. Participate in General Medical staff meetings without voting rights; and

b. Participate in medical staff committees without voting rights; and

c. Not hold office within the MEC or serve as a Committee Chair; and

d. Attend and participate in professional and educational opportunities of the medical staff available at SPH; and

e. Participate in decision making on behalf of the General Medical Staff, MEC, hospital leadership and operational board.

3.2.2 Responsibilities

a. Adhere to the hospital's medical staff Bylaws, Rules and Regulations, and policies as well as state and federal laws and regulations; an

b. Maintain professional standards of conduct, ethics and integrity; and

c. Participate in performance improvement activities, quality assurance and quality improvement activities; and

d. If providing inpatient or surgical services, remain in the geographic service area during the duration of the patient's stay or have coverage agreements acceptable to the credentials committee and MEC with a member of the SPH Medical Staff who holds the appropriate privileges.

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3.3 Community Staff Membership

3.3.1 **Qualifications**: The Community Staff Category is reserved for practitioners whom;

a. Are currently, or have previously, provided health and education services within the South Peninsula Hospital Service Area; or

b. Have retired

3.3.2 Prerogatives

Members of this category may:

a. Utilize and be affiliated with SPH for patient care but, do not have or intend to request privileges; and
b. Not attend general medical staff meetings, committees, voting or leadership opportunities; and
c. Attend and participate in professional and educational opportunities available at SPH.

3.2.4 Responsibilities

a. Maintain professional standards of conduct, ethics and integrity; and

b. This status is ongoing.

In the event that a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the Medical Staff and hospital, the member may be appointed to another Medical Staff category if they meet the eligibility requirements for such category.

3.4 Honorary Recognition (Non-Member)

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded at any time. Practitioners granted Honorary Recognition shall be those members who have retired from hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.

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Section 4. Officers and MEC Members-At-Large of the Medical Staff

4.1 Elected Officers of the Medical Staff

4.1.1 Chief of Staff

4.1.2 Vice Chief of Staff

4.1.3 Credentials Committee Chair

4.2 Qualifications of Officers and Members at Large

4.2.1 Officers, Physician & APP Members-at-Large must be in good standing, members of the Active category, and be actively involved in patient care, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office, be in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. The Medical Staff Nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

4.2.2 Officers and MEC members may not simultaneously hold a leadership position (MEC or Board) on SPH's, an unaffiliated hospitals, or Health System's medical staff that competes with the hospital. Noncompliance with this requirement, as determined by the MEC, will result in the officer being automatically removed from office.

4.3 Election of Officers and MEC Members-At-Large

4.3.1 The Nominating Committee is the MEC.

4.3.2 The Nominating Committee shall nominate candidate(s) for each of the positions of Chief of Staff, Vice Chief of Staff, Credentials Committee Chair, two physician Members-At-Large, and one APP Member-At-Large. The names of the nominees will be announced at least thirty (30) days prior to the election.

4.3.3 Any Active Member may submit their name or the name of another Active Member into nomination to the Medical Staff Office up to fourteen (14) days prior to the election for the nominee(s) to be reviewed by the Nominating Committee and placed on the ballot. The Nominating committee will determine if the candidate meets the qualifications in Section 4.2 above before the can be placed on the ballot.

4.3.4 Voting will occur at the final meeting of the year in even years. Voting must be done in person at the meeting or by electronic means; no proxy voting will be accepted.

4.3.5 If more than one candidate is on the ballot for an elected position(s) voting will be done by rank choice voting.

4.3.6 The Chief of Staff nominee receiving the majority of the vote, must be confirmed by the Board, prior to assuming office. If the Board does not confirm the Chief of Staff nominee, the Board shall discuss this with the current MEC, and instruct the MEC to reconvene the election process.

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4.4 Term of Office

All officers and each Member-at-Large position may serve a term of two (2) years. They shall take office on January 1st, in odd years, following their election. An individual may serve as an officer or member-at-large in each named position up to three (3) successive terms and cannot serve again until out of the position for at least two (2) years. Each officer and member-at-large shall serve in office until the end of the term of office or until a successor is elected or unless they resign sooner or is removed from office.

4.3 Removal and Resignation from Office

4.3.3 **Removal by Vote:** Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements that damage the hospital, its goals, or programs. The Medical Staff may initiate the removal of any officer if at least one-third (1/3rd) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3) supermajority of those Active staff members casting ballot votes, when a quorum of fifty percent (50%) is met.

4.3.4 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications for being an Officer, as noted in Part I, Section 4.2.1.

4.3.5 **Resignation:** Any elected officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

4.4 Vacancies of Office

The MEC shall fill vacancies of Office during the Medical Staff year, except the office of the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term. All other vacancies will be filled using the same election process as defined in Part I, Section 4.3.

4.5 Duties of Officers

4.7.1 **Chief of Staff:** The Chief of Staff shall represent the interests of the Medical Staff to the MEC and the Board. The Chief of Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the hospital. The Chief of Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff bylaws, rules, regulations, and policies. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the Medical Staff;

b. Serve as chair of the MEC and as ex officio member of all other Medical Staff committees without vote, and to participate as invited by the CEO or the Board on hospital or Board committees;

c. Enforce Medical Staff bylaws, rules, regulations, and Medical Staff/hospital policies;

d. Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with the chair of the Board, appoint the Medical Staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

e. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;

f. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

g. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

h. Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the Medical Staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

i. Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

j. Attend Board meetings as a non-voting ex-officio member and Board committee meetings as invited by the Board;

k. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff;

l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff bylaws; and

m. Authorize payments of Medical Staff funds.

4.7.2 **Vice Chief of Staff:** In the absence of the Chief of Staff or if the Chief of Staff has a conflict of interest that interferes with their participation, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. The VCOS shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.7.3 **Credentials Committee Chair:** The Chair of the Credentials Committee shall be an Officer of the Medical Staff. In the absence of both the Chief of Staff and Vice Chief of Staff, the Chair of the Credentials Committee shall assume the duties and have the authority of the Chief of Staff.

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Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

The Medical Staff shall be organized into a "department of the whole". There shall be Medical Staff Officers and Medical Staff committees to perform the major functions of the Medical Staff.

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Section 6. Committees

6.1 Designation and Substitution

There shall be a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual which is part of the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of the Medical Staff, rather than direct oversight by the Medical Staff, may be discharged by Medical Staff representation on such hospital committees as are established to perform such functions. The Chief of Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

a. Composition - voting: The MEC shall be a standing committee consisting of the following voting members: the Officers of the Medical Staff, the chair of the Peer Review Committee, two (2) physician Members-At-Large and one (1) Advanced Practice Professional Member-At-Large. A majority of the MEC must be physicians who are actively practicing in the Hospital. The chair will be the Chief of Staff.

b. Composition – nonvoting or ex officio: The non-voting attendees to the MEC shall consist of the CEO, CNO, CMO, COO, CFO, and up to two (2) privileged medical staff members of the Operating Board of Directors, as directed by the Operating Board of Directors.

c. Removal from MEC: A Medical Staff Officer who is removed from his/her position in accordance with Section 4.7 above will automatically lose his/her membership on the MEC.

6.2.2 **Duties:** The duties of the MEC, as delegated by the Medical Staff, shall be to:

a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff bylaws and provide oversight for all Medical Staff functions;

b. Provide recommendation(s) regarding, and coordination of policies adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, clinical privileges, and corrective action;

d. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the Board on medical administrative and hospital management matters;

g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the hospital;

h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

i. Review and act on reports from Medical Staff committees and other assigned activity groups;

j. Formulate and recommend Medical Staff rules, policies, and procedures to the Board;

k. Request evaluations of practitioners privileged through the Medical Staff process when there is question about an applicant or practitioner's ability to perform privileges requested or currently granted;

l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;

n. Oversee that portion of the corporate compliance plan that pertains to the Medical Staff;

o. Hold Medical Staff leaders and committees accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff bylaws;

q. The MEC will provide ad hoc ethical consultations should clinical ethical issues or concerns arise. Should an ethical issue or concern arise outside of the MEC's normal schedule; a Special Meeting may be called according to section 7.3. A Special Meeting called for an ethical consultation will be held within 48 hours.

r. The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.

6.2.3 **Meetings:** The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

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Section 7. Medical Staff Meetings

7.1 General Medical Staff Meetings

7.1.1 An annual and three (3) additional meetings of the General Medical Staff shall be held at a time determined by the MEC. Written or electronic notice of the meetings shall be given to all Medical Staff members stating the place, day, and hour of any regular meeting, not held pursuant to resolution, shall be delivered or sent to each member not less than five (5) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.1.2 The action of a majority of the Active members present and voting at a meeting of the General Medical Staff is the action of the group, except as otherwise specified in these bylaws. Only items posted on the agenda, at least forty-eight (48) hours in advance of the meeting may be voted upon at that meeting. Action may be taken without a meeting of the General Medical Staff by presentation of the question to each member eligible to vote, in person, electronically, and/or by mail, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Meetings of the General Medical Staff

a. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting if so directed by resolution of the MEC.

b. The Chief of Staff must call a special meeting if so directed by the Medical Staff with a petition signed by ten percent (10%) of the Active members. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting which shall occur within thirty (30) days of receipt of the petition.

c. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Committees shall meet as needed, unless otherwise stipulated in these bylaws.

7.3 Special Meetings of Committees

A special meeting of any committee may be called by the committee chair or by the Chief of Staff at a time to be determined by the committee chair or the Chief of Staff, but in no case less than five (5) days unless agreed upon by the whole of the committee or stipulated otherwise in these bylaws

7.4 Quorum

7.4.1 Medical Staff Meetings: Those eligible Medical Staff members present and voting on an issue.

7.4.2 MEC and Credentials Committee: A quorum will exist when fifty percent (50%) of voting members are present. When dealing with Category 1 requests for routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least two (2) members. If a quorum is not met at the Credentials Committee, the MEC shall function as the Credentials Committee.

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7.4.3 Peer Review Committee: A quorum will exist when fifty percent (50%) of voting members are present for making final determinations. Initial reviews including "no findings" can be conducted with two (2) members present, but final determinations require a 50% quorum.

7.5 Attendance Requirements

7.5.1 The Medical Staff attendance requirements are as follows:

a. Members of the Medical Staff are encouraged to attend meetings of the Medical Staff and are used to determine whether the Member is Active or Associate as noted in Part I, Section 3 of these Bylaws.

b. MEC meeting: Members of this committee are expected to attend at least two-thirds (2/3rds) of the meetings held on an annual basis. Failure to meet the attendance requirement may result in replacement on the committee. Individuals may call in to meetings, at the chairman's discretion, and only if certain conditions on confidentiality are met.

c. Special meeting attendance requirements : Non-Committee Member: Whenever there is a reason to believe that a practitioner is not complying with Medical Staff or hospital policies or has deviated from standard clinical or professional practice, the Chief of Staff or the applicable Medical Director or Medical Staff committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic termination of the practitioner's membership and privileges. Such termination would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

d. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the CEO

The CEO and/or his/her designee may attend any general medical staff or committee meeting of the Medical Staff as an ex-officio member without vote.

7.7 Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure.

7.8 Action of Committee

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee. Such recommendation will then be forwarded to the MEC for action. If a committee vote results in a tie, the issue will be forwarded to the committee it reports to, for further action.

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7.9 Rights of Ex Officio Members

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.10 Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair shall authenticate the minutes. A permanent file of the minutes of each meeting shall be maintained.

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Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a committee composed of the Officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the chair of the Board, CEO, CMO, or the Chief of Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.4 of Part I of these bylaws.

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Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The Medical Staff shall have the responsibility to formulate, review at least triennially, and recommend to the Board any Medical Staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws and rules & regulations shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

9.2.1 Initiation by MEC. Proposed adoption and/or amendments to these bylaws may be originated by Medical Staff leadership. Once approved by the MEC, the adoption and/or amendment will be sent to the Medical Staff for review and then for vote in no less than thirty (30) days.

9.2.2 Initiation by the Medical Staff. Proposed amendments to these bylaws may be originated by a petition signed by ten percent (10%) of the Members of the Active category.

9.2.3 Approval Process.

a. The bylaws adoption and/or amendments will be voted on at a general Medical Staff meeting. For approval, there must be a two-thirds (2/3rds) supermajority vote of the votes cast, when a quorum is present.

b. Adoption and/or amendments so adopted shall be effective when approved by the Board.

9.3 Methods of Adoption and Amendments to any Medical Staff Rules, Regulations, and Policies

9.3.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.

9.3.2 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote.

9.3.3 After thirty (30) day notice to the Medical Staff, the MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

9.3.4 In addition to the process described in 9.3.2 above, the organized Medical Staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

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9.3.5 In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC immediately informs the Medical Staff. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If, after fifteen (15) days, there is less than a quorum of fifty percent (50%) of the Active Staff noting disapproval of the urgent amendment, the provisional amendment stands. If there is greater than fifty percent (50%) of the Active Staff noting disapproval of the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.

9.3.6 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff bylaws or rules and regulations.

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South Peninsula Hospital and Long Term Care Facility

MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

September 29, 2021

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Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Criteria for Initiation

These bylaws encourage Medical Staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve his/her clinical skills or professional behavior, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and hospital. Collegial intervention efforts may include but are not limited to the following:

a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

c. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following collegial intervention efforts, if it appears that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency.

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted in writing by a Medical Staff officer, Medical Staff committee chair, Medical Director, CEO, or hospital Board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons and notify the practitioner.

2.2 Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CEO. The investigating body may also require, with the approval of the Chief of Staff and the CEO, the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The investigating body shall notify the practitioner in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

2.2.1 An external peer review consultant should be considered when:

a. Litigation seems likely;

b. The hospital is faced with ambiguous or conflicting recommendations from Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances, consideration may be given by the MEC or the Board to retain an objective external reviewer;

c. There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review.

2.3 MEC Action

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

a. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;

b. Deferring action for a reasonable time when circumstances warrant;

c. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Medical Directors from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file;

d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

f. Recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;

g. Recommending suspension, revocation, or probation of Medical Staff membership; or

h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, the practitioner shall be entitled to the procedural rights afforded in this hearing and appeal plan. The Board shall act on the MEC's recommendation unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following triggering circumstances, the practitioner's privileges and/or membership will be considered relinquished, suspended, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The Chief of Staff with the approval of the CEO may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty days, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

3.1.1 **Licensure**

a. **Revocation and suspension:** Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Medical Staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

b. **Restriction:** Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. **Probation:** Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

3.1.2 **Medicare, Medicaid, Tricare** (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a practitioner is excluded or precluded from participation in Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.3 **Controlled Substances**

a. **DEA Certificate:** Whenever a practitioner's United States Drug Enforcement Administration (DEA) certificate is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. **Probation:** Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.4 **Medical Record Completion Requirements:** A practitioner will have their privilege to admit new patients, schedule new procedures/visits automatically suspended whenever they fail to complete medical records within time frames established by the MEC. This suspension of privileges shall not apply to patients admitted or already scheduled at the time of suspension, to emergency patients, or to imminent deliveries. The suspended privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.5 **Professional Liability Insurance:** Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and Medical Staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic suspension of a practitioner's clinical privileges. If within sixty (60) calendar days of the suspension the practitioner does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The practitioner must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage.

3.1.6 **Medical Staff Dues/Special Assessments:** Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic suspension of a practitioner's appointment. If within sixty (60) calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the Medical Staff.

3.1.7 **Felony Conviction:** A practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a barrier crime, as defined in 7 AAC 10.905, shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary. This does not preclude the MEC from taking action on charges or indictments of the above or other offenses.

3.1.8 **Failure to Satisfy the Special Appearance Requirement:** A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have all clinical privileges with the exception of emergencies and imminent deliveries automatically suspended. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.9 **Failure to Participate in Required Testing:** A practitioner who fails to participate in required testing, as noted in Part I, Section 2.6.4, and authorizes release of this information to the MEC, shall be considered to have all privileges automatically suspended. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.10 **Failure to become board certified or failure to maintain current board certification:** A practitioner who fails to become board certified in compliance with these bylaws or Medical Staff credentialing policies will be deemed to have voluntarily relinquished his or her Medical Staff appointment and clinical privileges, becoming effective at the next reappointment date. If a practitioner fails to become recertified, a grace period of one (1) year to become recertified may be granted by the MEC upon an appropriate justification. A practitioner who fails to be recertified in compliance with these bylaws or medical staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and clinical privileges.

3.1.11 **Failure to Maintain a Collaborative/Supervisory Practice Agreement:** All APPs with inpatient privileges are required to have a collaborative/supervisory practice agreement with a physician. If a physician severs this agreement, or is no longer privileged by South Peninsula Hospital, the APP cannot practice until there is a collaborative/supervisory practice agreement with another physician.

3.1.12 **Failure to Execute Release and/or Provide Documents:** A practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the Chief of Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have all privileges automatically suspended. If the release is executed and/or documents provided within thirty (30) calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. After thirty (30) calendar days, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.1.13 **MEC Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these bylaws.

3.3 Precautionary (Summary) Restriction or Suspension

3.3.1 Criteria for Initiation: A precautionary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when Medical Staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to adversely affect patient or employee safety or the effective operation of the institution. Under such circumstances one (1) Medical Staff leader (such as a Medical Staff Officer) in conjunction with one (1) administrator (such as CEO, CMO, or administrator on call) restrict or suspend the Medical Staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital.

Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the CEO, and the Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another Medical Staff member by the Chief of Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

3.3.2 MEC Action: As soon as feasible and within fourteen (14) calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event, it shall furnish the practitioner with notice of its decision.

3.3.3 Procedural Rights: Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the member or other physician or dentist with privileges without membership (or applicant for the above) shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for Medical Staff appointment or physicians eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following "adverse actions" when the basis for such action is related to clinical competence or professional conduct:

a. Denial of Medical Staff appointment or reappointment;

b. Revocation of Medical Staff appointment;

c. Denial or restriction of requested clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;

d. Involuntary reduction or revocation of clinical privileges;

e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member and is imposed for more than fourteen (14) calendar days; or

f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

a. Issuance of a letter of guidance, warning, or reprimand;

b. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on privileges;

c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;

d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;

e. Requirement to appear for a special meeting under the provisions of these bylaws;

f. Automatic relinquishment or voluntary resignation of appointment or privileges;

g. Imposition of a precautionary suspension that does not exceed fourteen (14) calendar days;

h. Denial of a request for leave of absence, or for an extension of a leave;

i. Determination that an application is incomplete or untimely;

j. Determination that an application will not be processed due to misstatement or omission;

k. Decision not to expedite an application;

l. Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;

n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;

o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

p. Termination of any contract with or employment by hospital;

q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any regulatory standards on focused professional practice evaluation;

r. Any recommendation voluntarily accepted by the practitioner;

s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

t. Change in assigned staff category;

u. Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;

v. Removal or limitations of emergency department call obligations;

w. Any requirement to complete an educational assessment;

x. Retrospective chart review;

y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;

z. Grant of conditional appointment or appointment for a limited duration; or

aa. Appointment or reappointment for duration of less than 24 months.

4.3 Notice of Recommendation of Adverse Action

When a precautionary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the CEO delivered either in person or by certified mail, return receipt requested. This notice shall contain:

a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);

b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation;

c. Notice that the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

d. The individual shall receive a copy of Part II of these bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the CEO or designee. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final Board action.

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the CEO shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

a. The time, place, and date of the hearing;

b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the Board), at the hearing;

c. The names of the hearing panel members and presiding officer or hearing officer, if known; and

d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, 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 individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

a. When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed. This panel will be appointed by the Hospital CEO, in conjunction with the Chief of Staff. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the hospital Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

b. The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is in professional practice with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

c. The CEO or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the CEO. The Hospital CEO shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, the practitioner is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the Hospital CEO.

5.2 Hearing Panel Chairperson or Presiding Officer

5.2.1 In lieu of a hearing panel chair, the CEO, acting for the Board and after considering the recommendations of the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no previous relationship with either the hospital, organized Medical Staff, or the practitioner. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

5.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the CEO to serve as the presiding officer and shall be entitled to one vote.

5.2.3 The presiding officer (or hearing panel chair) shall do the following:

a. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;

g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and

h. Seek legal counsel when they feel it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

5.3 Hearing Officer

5.3.1 As an alternative to the hearing panel described above, the CEO, acting for the Board and in conjunction with the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-clinical matters.

5.3.2 The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the "hearing panel" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 There is no right to formal "discovery" in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;

b. Reports of experts relied upon by the MEC;

c. Copies of redacted relevant committee minutes;

d. Copies of any other documents relied upon by the MEC or the Board;

e. No information regarding other practitioners shall be requested, provided, or considered; and

f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

6.1.2 Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

6.1.3 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.

6.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel, or hearing officer.

6.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Alaska.

6.5 Rights of the Practitioner and the Hospital

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

a. To call and examine witnesses to the extent available;

b. To introduce exhibits;

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

d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may argue the case for his/her client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;

e. To submit a written statement at the close of the hearing.

6.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

6.5.3 The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Burden of Proof

It is the burden of the MEC (or Operating Board of Directors) to demonstrate that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate that they satisfy, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all Medical Staff and hospital policies.

6.8 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed with ten (10) business days, following the close of the hearing.

6.9 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.10 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the presiding officer or the CEO on a showing of good cause.

6.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief of Staff or CEO. All members of the hearing panel shall be present, absent good cause, for all stages of the hearing and deliberations. If a hearing panel member is absent from any portion of the hearing, they shall not be able to deliberate or vote until they have reviewed the transcript for the period of their absence.

6.12 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

6.13 Basis of Recommendation

The hearing panel shall recommend in favor of the MEC (or the Board) unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

6.14 Adjournment and Conclusion

The presiding officer may recess the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

6.15 Deliberations and Recommendation of the Hearing Panel

Within ten (10) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.16 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the CEO who shall forward it, along with all supporting documentation, to the Board for further action. The CEO shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment. If the hearing panel report confirms the original adverse recommendation, the practitioner shall have the right to appellate review as outlined below. If the hearing panel report differs from the original MEC or Board recommendation, the MEC or Board may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the affected practitioner, including a statement of the basis for its recommendation.

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, or after the MEC or Board makes its final recommendation, either the practitioner subject to the hearing or the MEC may appeal an adverse recommendation. The request for appellate review shall be in writing, and shall be delivered to the CEO or designee either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the Medical Staff bylaws prior to or during the hearing so as to deny a fair hearing; or

b. The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or

c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place, and Notice

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

a. The chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The review panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Alaska.

c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

d. The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or Medical Staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member or a physician or dentist with privileges without membership, that individual may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

South Peninsula Hospital and Long Term Care Facility

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

DATE

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Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the Credentials Committee shall consist of the Chair of the Credentials Committee, two (2) other physician Members, and one (1) Advanced Practice Professional Member.

Members will be appointed for terms of two (2) years and may be reappointed for additional terms without limit.

An Administrative representative, and a Board representative, shall be a nonvoting ex-officio members of the committee.

1.2 Meetings

The Medical Staff Credentials Committee shall meet on the call of the chair or Chief of Staff.

1.3 Responsibilities

1.3.1 To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;

1.3.2 To review and recommend action on all requests regarding privileges from eligible practitioners;

1.3.3 To recommend eligibility criteria for the granting of Medical Staff membership and privileges;

1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

1.3.5 To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff or hospital leaders;

1.3.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

1.4.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical Staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the CEO or designee.

1.4.2 Individual practitioners may review their credentials file under the following circumstances:

Only upon written request approved by the Chief of Staff, CEO, or Credentials Chair. Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from the file. Only items supplied by the practitioner or directly addressed to the practitioner may be copied and given to the practitioner. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership with Privileges

2.1 No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, certification, or privileges at any other healthcare organization.

2.2 The following qualifications must be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or clinical privileges:

2.2.1 Demonstrate that they have successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.2.2 Have a current state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Alaska. The license must be unrestricted for initial appointment;

2.2.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities;

2.2.4 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to a barrier crime, as defined in 7 AAC 10.905;

2.2.5 A physician applicant, MD, or DO, 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 any foreign board acknowledged by the American board, and be currently board certified or become board certified within five (5) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties, National Board of Physician and Surgeons (not as initial board certification), or the American Osteopathic Association, or any foreign board acknowledged by the American board;

2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.7 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery, or any foreign board acknowledged by the American board;

2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Foot and Ankle Surgery and the American Board of Podiatric Medicine;

2.2.9 A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either is required for initial applicants or be actively seeking initial certification and obtain the same on the first examination for which eligible and reapplicants.

2.2.10 A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program. Current active certification by the American Midwifery Certification Board (AMCB), or be actively seeking initial certification and obtain the same on the first examination for which eligible is required for initial applicants and reapplicants.

2.2.11 A nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse Practitioners Certification Board or an equivalent body is required for initial applicants or be actively seeking certification and obtain the same on the first examination for which the applicant is eligible and reapplicants.

2.2.12 A physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C is required for initial applicants and reapplicants.

2.2.13 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

2.2.14 Possess a current and valid Drug Enforcement Administration (DEA) number if applicable. The DEA must be unrestricted for initial appointment;

2.2.15 Possess a valid NPI number;

2.2.16 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Medical Staff membership and/or the specific privileges requested by and granted to the applicant;

2.2.17 Have appropriate written and verbal communication skills;

2.2.18 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

b. A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.

2.3.7 Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

2.3.8 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

2.3.9 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital.;

2.3.10 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

2.4 Qualifications of Membership without Privilege

2.4.1 Have a current state, federal, or have previously held a state or federal license, as a practitioner, applicable to his or her profession.

2.4.2 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities;

2.4.3 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to a barrier crime, as defined in 7 AAC 10.905;

2.4.4 No practitioner shall be entitled to membership on the Medical Staff merely by virtue of licensure, membership in any professional organization, certification, or privileges at any other healthcare organization.

2.5 Exceptions

2.4.1 Physicians applying to the medical staff after January, 2009 shall be required to have current board certification. All practitioners who are current Medical Staff Members and/or hold privileges as of January, 2009 and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

2.5.1 Only the Board may create additional exceptions but only after consultation with the MEC and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, the Medical Staff office will provide the applicant the appropriate application package, which will include a complete set or overview of the Medical Staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges.

3.1.1.1 A completed application form for membership and clinical privileges includes, at minimum:

a. A completed, signed, dated application form;

b. A completed privilege delineation form if requesting privileges;

c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency. Which may including procedure or activity logs, and/or OPPE as requested;

d. All applicable fees

e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card;

f. Receipt of two (2) directed references, if possible; references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested. One (1) nondirected references will also be queried. At least one reference must be from someone in the same professional discipline;

g. Relevant practitioner-specific data as compared to aggregate data, when available;

h. Membership Category requested;

i. ECFMG for foreign graduates only;

j. Visa (H-1B or J-1) for non-US citizens only;

k. DD-14 to document military service, if applicable; and

l. Morbidity and mortality data, when available.

3.1.2 A completed application for membership only includes, at minimum:

a. A completed, signed, dated application form;

b. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card;

c. Membership Category requested;
d. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken.

3.1.3 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter/email requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

3.1.4 Upon receipt of a completed application the credentials chair, in collaboration with the Medical Staff office, will determine if the requirements of Sections 2.2, 2.3, and 2.4 are met. In the event the requirements of Sections 2.2,2.3 and 2.4 are not met, the potential applicant will be notified that they are ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of Sections 2.2, 2.3 and 2.4 are met, the application will be accepted for further processing.

3.1.5 Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

3.1.6 Upon receipt of a completed application, the Medical Staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the Medical Staff office will collect relevant additional information which may include:

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any) for their lifetime;

b. Verification of the applicant's past clinical work experience for at least the past five (5) years;

c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the Medical Staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

d. Information from the AMA or AOA Physician Profile and OIG list of Excluded Individuals/Entities or SAM (System for Award Management);

e. Information from professional training programs including residency and fellowship programs;

f. Information regarding board certification status from the applicable board;

g. Information from the National Practitioner Data Bank (NPDB); in addition, the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;

h. Other information about adverse credentialing and privileging decisions;

i. Three (3) peer recommendations selected by the Credentials Committee chosen from practitioners who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges;

j. Information from a State of Alaska fingerprinted criminal background check;

k. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges; and

l. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available.

Note: In the event there is undue delay in obtaining required information, the Medical Staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five calendar days will be deemed a withdrawal of the application.

3.1.6 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization, and Acknowledgement

The applicant must complete and sign the application form. By signing this application, the applicant:

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any substantive inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

3.2.2 Consents to appear for any requested interviews in regard to his/her application.

3.2.3 Authorizes the hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

3.2.4 Consents to hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of:

a. Professional qualifications and competence to carry out the clinical privileges requested;

b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;

c. Professional and ethical qualifications;

d. Professional liability actions including currently pending claims involving the applicant; and

e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the Medical Staff, including otherwise privileged or confidential information to the hospital representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

3.2.6 Authorizes the hospital Medical Staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment, or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against any Medical Staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.

3.2.7 Acknowledges that the applicant has had access to the Medical Staff bylaws, including all rules, regulations, policies and procedures of the Medical Staff, and agrees to abide by their provisions.

Notwithstanding Sections 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, the practitioner shall reimburse the hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

3.2.8 Agrees to provide accurate answers to the questions on the application, and agrees to immediately notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the application questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Application Evaluation

3.3.1 **Credentialing Process:** An expedited review and approval process may be used for initial appointment or for reappointment. All initial and reappointment applications for membership and/or privileges will be designated Category 1 or Category 2 as follows;

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and action by the following: credentials chair acting on behalf of the Credentials Committee, the MEC approve, and a Board committee consisting of at least two individuals approve.

Category 2: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the, Credentials Committee, MEC, and the Board. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that they meet the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

a. The application is deemed to be incomplete;

b. The final recommendation of the MEC is adverse or with limitation;

c. The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;

d. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

e. Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years;

f. Applicant changed medical schools or residency programs or has gaps in training or practice;

g. Applicant has changed practice affiliations more than three times in the past ten (10) years, excluding telemedicine and locum tenens practitioners;

h. Applicant has one or more reference responses that raise concerns or questions;

i. Discrepancy is found between information received from the applicant and references or verified information;

j. Applicant has an adverse National Practitioner Data Bank report related to behavior;

k. The request for privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;

l. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;

m. Applicant has potentially relevant physical, mental, and/or emotional health problems;

n. Other reasons as determined by a Medical Staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.

3.3.2 Applicant Interview

a. All applicants for appointment to the Medical Staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Credentials Committee, MEC, or Board. The interview may take place in person, by telephone or electronic means at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate Medical Staff performance expectations.

b. Procedure: the applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview within forty-five (45) days of completion of his or her application will be deemed a withdrawal of the application.

3.3.3 Medical Staff Credentials Committee Action

All completed applications are presented to the Chair of the Credentials Committee for review, and recommendation. The Chair of the Credentials Committee reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Chair of the Credentials Committee, in consultation with the Medical Staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The Chair of the Credentials Committee may obtain input if necessary from an appropriate subject matter expert. If the Chair of the Credentials Committee believes a conflict of interest exists that might preclude their ability to make an unbiased recommendation, they will notify the MEC chair and forward the application without comment. If forwarded as a Category 1, the credentials chair acts on behalf of the Medical Staff Credentials Committee and the application is presented to the MEC for review and recommendation. If designated Category 2, the Medical Staff Credentials Committee reviews the application and forwards the following to the MEC:

a. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

b. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

c. Comments to support these recommendations.

3.3.4 MEC Action

If the application is designated Category 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing, as noted in Part I, Section 7.4.2. The Chief of Staff has the opportunity to determine whether the application is forwarded as a Category 1, or may change the designation to a Category 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;

b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

d. Comments to support these recommendations.

Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.5 Board Action:

The Board reviews the application and votes for one of the following actions:

a. If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Category 2 applications will be followed.

b. If the application is designated as a Category 2, the Board reviews the application and votes for one of the following actions:

   i. The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;

ii. If the Board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or

iii. The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.6 **Notice of Final Decision:** Notice of the Board's final decision shall be given, through the CEO to the MEC. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the clinical privileges they may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.3.7 **Time Periods for Processing:** All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Reappointment

4.1 Criteria for Reappointment

It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in Section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in Section 4.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing Medical Staff members or other practitioners with privileges will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 6.1 below concerning focused professional practice evaluation.

4.2 Information Collection and Verification

4.2.1 **From appointee:** On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least two (2) months prior to this date the practitioner must return the following to the Medical Staff office:

a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;

b. By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above.

4.2.2 From internal and/or external sources: The Medical Staff office collects and verifies information regarding each practitioner's professional and collegial activities to include those items listed in Section 3.2.8, items a. to y.

4.2.3 The following information is also collected and verified:

a. A summary of clinical activity at this hospital for each practitioner due for reappointment;

b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;

c. Service on Medical Staff and hospital committees;

d. Timely and accurate completion of medical records;

e. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and Medical Staff;

f. Any significant gaps in employment or practice since the previous appointment or reappointment;

g. Verification of current licensure;

h. National Practitioner Data Bank query, information from the OIG List of Excluded Individuals/Entities or SAM (System for Award Management) and FSMB (Federation of State Medical Boards); state Medicaid exclusion list;

i. An Alaska state criminal background check will be done at least every five (5) years;

j. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the Credentials Committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges; and

k. Malpractice history for the past two (2) years, which is primary source verified by the Medical Staff office with the practitioner's malpractice carrier(s).

4.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff office verifies this additional information and notifies the practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

4.3 Evaluation of Application for Reappointment of Membership and/or Privileges

4.3.1 The reappointment application will be reviewed and acted upon as described in Sections 3.3.3 through 3.3.8 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in Section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the Medical Staff bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment."

Section 5. Clinical Privileges

5.1 Exercise of Privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board, upon recommendation of the MEC to practitioners who are not members of the Medical Staff. Such individuals may be physicians serving short locum tenens positions, telemedicine physicians, or others deemed appropriate by the MEC and Board.

5.2 Requests

When applicable, each application for appointment or reappointment to the Medical Staff or for privileges must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

5.3 Basis for Privileges Determination

5.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

5.3.2 Privileges for which no criteria have been established:

In the event a request for a privilege is submitted for a new technology, a new service, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time, the MEC will:

a. Review the community, patient, and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;

b. Review with members of the Credentials Committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);

c. Meet with management to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information, and staffing plans; and

d. Work with management to ensure that any/all exclusive contract issues, if applicable are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the Credentials Committee, or subject matter experts (as determined by the Credentials Committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein:

i. The requesting practitioner may be requested to provide a full briefing concerning the new technique or procedure including names of other hospitals in which it is used, any peer-reviewed research, any product literature or educational syllabus and the names of any residency or other training directors responsible for providing training in this area;

ii. For the development of criteria, the Medical Staff service professional (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to position and opinion papers from specialty organizations, white papers, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate. The requesting practitioner may be requested to provide a full briefing concerning the new technique or procedure including names of other hospitals in which it is used, any peer-reviewed research, any product literature or educational syllabus and the names of any residency or other training directors responsible for providing training in this area;

iii. Criteria to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed including who may serve as proctor and how many proctored cases will be required.

iv. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate hospital administrator and/or department director; and

v. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the credentials chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the Credentials Committee who has no vested interest in the issue.

5.3.3 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privilege determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

5.3.4 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

5.4 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence.

5.5 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a member of the Medical Staff that will be recorded in the medical record. Podiatrists may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in podiatric surgery and demonstrated current competence as permitted through their scope of practice as defined by the State.

5.6 Special Conditions for Practitioners Eligible for Privileges Without Membership

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership, with the exception that such individuals are not eligible for membership on the Medical Staff and do not have the rights and privileges of such membership.

Special Conditions for APP Students, Residents or Fellows in Training

5.6.1 APP Students, Residents or fellows (herby referred as to 'trainee') in training in the hospital shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the applicable supervising provider in conjunction with the training program, Medical Staff Student Policy, and Medical Staff Rules and Regulations 3.18. The protocols must delineate the roles, responsibilities, and patient care activities of trainees including which types of trainees may write patient care orders, under what circumstances why they may do so, and what entries a supervising provider must countersign. The protocol must also describe the mechanisms through which supervising providers make decisions about a trainee's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and hospital leaders.

5.6.2 The applicable supervising provider must communicate periodically with the MEC and the Board about the performance of trainees' patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising providers possess clinical privileges commensurate with their supervising activities.

5.7 Telemedicine Privileges

Telemedicine privileges are limited to those services the Board has approved for telemedicine delivery. Should a Telemedicine practitioner desire membership, they must request membership in addition to privileges.

Requests for telemedicine privileges at the Hospital that includes patient care, treatment, and services will be reviewed by the MEC and will be processed through one of the following mechanisms:

a. The Hospital fully privileges and credentials the practitioner; **OR**

b. The Hospital privileges practitioners using credentialing information from the distant site if the distant site is a Medicare-participating Hospital or telemedicine entity and the information is then processed through the routine medical staff credentialing and privileging process. The distant-site practitioner must have an Alaska license; **OR**

c. The hospital uses the credentialing and privileging decision from the distant site if all of the following requirements are met:

   i. The distant site is a Medicare-participating hospital or ambulatory care organization;

   ii. The practitioner is privileged at the distant site for those services to be provided at this hospital and the practitioner has an Alaska license; and

   iii. The hospital has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel, or never events that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the hospital.

5.8 Temporary Privileges

The CEO, or designee, acting on behalf of the Board and based on the recommendation of the Chief of Staff or designee, and Credential Committee Chair, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

5.8.1 Important Patient Care, Treatment, or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges, the organized Medical Staff verifies current licensure, current competence, and checks that a criminal background check has been done ensuring there have been no barrier crimes.

5.8.2 Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include 1) complete application 2) fully verified application, and 3) positive recommendation from the Credentials Committee or Credentials Committee Chair on behalf of the Committee. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in Section 3 of this manual.

5.8.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

5.8.4 Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the Chief of Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose a precautionary suspension under the Medical Staff bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Chief of Staff or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

5.8.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

5.9 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of staff category or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

5.10 Disaster Privileges:

5.10.1 If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

a. A current picture hospital ID card that clearly identifies professional designation;

b. A current license to practice;

c. Primary source verification of the license;

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

e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

f. Identification by a current hospital or Medical Staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

5.10.2 The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

5.10.3 The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

5.10.4 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

5.10.5 Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

5.10.6 Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

Section 6. Clinical Competency Evaluation

6.1 Initial Focused Professional Practice Evaluation (I-FPPE)

All initially requested privileges shall undergo a period of FPPE. The Credentials Committee, with the approval of the MEC, will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such I-FPPE and triggers that indicate the need for performance monitoring.

6.2 Ongoing Professional Practice Evaluation (OPPE)

The Medical Staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

6.3 Practitioner Re-Entry

A practitioner who has not provided acute inpatient care within the past two (2) years who requests clinical privileges at the hospital must complete a formal process to assess and confirm clinical competence as determined by the Credentials Committee.

A practitioner that has not provided any clinical care within the past five (5) years as determined by the Alaska medical licensing board or the MEC is required to complete a formal re-entry process through an ACGME or AOA accredited residency program. The practitioner must assume responsibility for any financial costs required to fulfill these requirements. If additional formal training is required, a description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the Credentials Committee and MEC. At a minimum, the preceptorship or training program description must include the following:

a. The scope and intensity of the required activities;

b. The requirement for submission of a written report from the preceptor or training program prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication After Adverse Credentials Decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for Modification of Appointment Status or Privileges

A practitioner, either in connection with reappointment or at any other time, may request modification of staff category or clinical privileges by submitting a written request to the Medical Staff office. A modification request must contain all pertinent information supportive of the request. Practitioners are limited to one category modification request during their 2 year reappointment cycle. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, unless reappointed within 3 months of the request, which is outlined in Section 5 of this manual. A practitioner who determines that they no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that they have been granted shall send written notice, through the Medical Staff Office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of Staff Appointment or Privileges

A practitioner who wishes to resign their staff appointment and/or clinical privileges must provide written notice to the Chief of Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns their staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which they are responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of Administrative Remedies

Every practitioner agrees that they will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

7.5 Reporting Requirements

The CEO or his/her designee shall be responsible for assuring that the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 8. Leave of Absence

8.1 Leave Request

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than one hundred (100) consecutive days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. A leave of absence should be requested sixty (60) days before the anticipated absence, unless it is a medical emergency. Under such circumstances the CEO, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the Chief of Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed two (2) years except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. Leaves of absence are matters of courtesy, not of right. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Chief of Staff and Medical Staff Office. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

8.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these bylaws. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Section 9. Practitioners Providing Contracted Services

9.1 When the hospital contracts for care services with licensed independent practitioners who provide readings of images, tracings, or specimens through a telemedicine mechanism, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

9.2 Exclusivity policy

Whenever hospital policy specifies that certain hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the hospital and qualified practitioners, then other practitioners must, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Practitioners who have previously been granted privileges, which then become covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

9.3 Qualifications

A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

9.4 The terms of the Medical Staff bylaws will govern disciplinary action taken by or recommended by the MEC.

9.5 Effect of Contract or Employment Expiration or Termination

The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

Section 10. Medical Directors

10.1 A Medical Director is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

10.2 Each Medical Director must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

10.3 Effect of removal from the medical directorship or adverse change in appointment status or clinical privileges:

10.3.1 Where a contract exists between the Medical Director and the hospital, its terms govern the effect of removal of the medical directorship on the Medical Director's staff appointment and privileges and the effect an adverse change in the Medical Director's staff appointment or clinical privileges has on his remaining in office.

10.3.2 In the absence of a contract or where the contract is silent on the matter, removal from the medical directorship has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in the medical directorship will be as determined by the Board.

10.3.3 A Medical Director has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from the medical directorship.

South Peninsula Hospital and Long Term Care Facility

MEDICAL STAFF BYLAWS

Organization and Functions Manual

September 29, 2021

Table of Contents

Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

The Medical Staff shall be organized as a "department of the whole". There shall be Medical Staff Officers and Medical Staff committees to perform the major functions of the Medical Staff.

1.2 Responsibilities for Medical Staff Functions

The organized Medical Staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The Medical Staff officers and hospital and Medical Staff committee chairs, are responsible for working collaboratively to accomplish required Medical Staff functions. This process may include periodic reports as appropriate to the appropriate committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

The Medical Staff, acting as a whole or through committee, participates in or has oversight over the following activities:

1.3.1 Governance, direction, coordination, and action

a. Receive, coordinate, and act upon, as necessary, the reports and recommendations from committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of practitioners with privileges when warranted;

d. Make recommendations on medical, administrative, and hospital clinical and operational matters;

e. Inform the Medical Staff of the accreditation and state licensure status of the hospital;

f. Act on all matters of Medical Staff business, and fulfill any state and federal reporting requirements;

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the Medical Staff and governing body; and

j. Ensure effective, timely, and adequate comprehensive communication between the members of the Medical Staff and Medical Staff leaders as well as between Medical Staff leaders and hospital administration and the Board.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. These functions are defined within the Peer Review Policy.

1.3.3 Hospital Performance Improvement and Patient Safety Programs

a. Understand the Medical Staff's and administration's approach to and methods of performance improvement;

b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and

d. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 Credentials review (see Part III: Credentials Procedures Manual)

1.3.5 Information Management

a. Review and evaluate medical records to determine that they:

i. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

ii. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

b. Develop, review, enforce, and maintain surveillance over enforcement of Medical Staff and hospital policies and rules relating to medical records including completion, preparation, forms, and format and recommend methods of enforcement thereof and changes therein; and

c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.3.6 Emergency Preparedness

Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

1.3.7 Strategic Planning

a. Participate in evaluating existing programs, services, and facilities of the hospital and Medical Staff; and recommend continuation, expansion, abridgment, or termination of each;

b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to Medical Staff members.

1.3.8 Bylaws review

a. Conduct periodic review of the Medical Staff bylaw, rules, regulations, and policies; and

b. Submit written recommendations to the MEC and to the Board for amendments to the Medical Staff bylaws, rules, regulations, and policies.

1.3.9 Nominating

a. Identify nominees for election to the officer positions and to other elected positions in the Medical Staff organizational structure; and

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.10 Infection Prevention and Control Oversight

a. The Medical Staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;

b. Develop and approve policies describing the type and scope of surveillance activities including:

i. Review of cumulative microbiology recurrence and sensitivity reports;

ii. Review of prevalence and incidence studies, as appropriate; and

iii. Collection of additional data as needed.

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and

h. Review all policies and procedures on infection prevention, surveillance, and control at least biennially.

1.3.11 Pharmacy and Therapeutics Functions

a. Maintain a formulary of drugs approved for use by the hospital;

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by regulatory authorities;

f. Perform practitioner analysis related to medication use;

g. Approve policies and procedures related to regulatory standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

h. Develop and measure indicators for the following elements of the patient treatment functions:

i. Prescribing/ordering of medications;

ii. Preparing and dispensing of medications;

iii. Administrating medications; and

iv. Monitoring of the effects of medication.

i. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;

j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

k. Serve as an advisory group to the hospital and Medical Staff pertaining to the choice of available medications; and

l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.12 Practitioner Health

a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental, physical, or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;

b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;

c. Notify the MEC whenever the impaired practitioner's actions could endanger patients;

d. Create opportunities for referral (including self-referral) while maintaining confidentiality to the greatest extent possible; and

e. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

1.3.13 Utilization Management Functions

a. Study recommendations from Medical Staff members, quality assessment coordinators and others to identify problems in utilization and the review program;

b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;

c. Forward all unjustified cases in any review category to the appropriate committee for review and action;

d. Review case-mix financial data and any other internal/external statistical data;

e. Upon review of any data, conduct further studies, perform education or refer the data to the Medical Staff Quality Committee for their review and action;

f. Develop, with the aid of legal counsel, policies to guide the director of utilization management, Medical Staff, and administration in matters of privileged communication and legal release of information;

g. Develop a utilization management plan for approval by the Board;

h. These functions shall be accomplished by the utilization management committee consisting of at least two (2) physician members of the Medical Staff.

Section 2. Medical Staff Committees

2.1 General Language Governing Committees

The following shall be the standing committees of the Medical Staff: Medical Executive, Credentials, and Peer Review. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The Chief of Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the Chief of Staff when establishing the committee. The Chief of Staff and the CEO, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the Chief of Staff or by action of the MEC for failure to remain a member of the Medical Staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical Staff members may be appointed to hospital committees by the CEO. The following hospital committees shall have Medical Staff Members on the committee: Pharmacy and Therapeutics, Infection Prevention, Utilization Management/Medical Records, and Quality Improvement. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

2.2 MEC

Description of the MEC is in Part I: Governance; Section 6.2.

2.3 Credentials Committee

Description of the Credentials Committee is in Part III: Credentials Procedures Manual; Section 1.

2.4 Peer Review Committee

2.4.1 Composition: The Peer Review Committee shall be defined in the Peer Review Policy.

Responsibilities: The committee shall be responsible for those functions defined in the Peer Review Policy.

2.5 Nominating Committee

2.4.1 Composition: The Nominating Committee is the MEC

2.4.2 Responsibilities: The committee shall provide a slate of nominees for the elected Medical Staff positions.

Section 3. Confidentiality, Immunity, Releases, and Conflict of Interest

3.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- Contributions to teaching or clinical research; or
- Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

3.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or Medical Staff. No representative of this healthcare organization acting in good faith and without malice shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

3.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facilities or organization's activities concerning, but not limited to:

a. Applications for appointment/affiliation, clinical privileges, or specified services;

b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;

c. Corrective or disciplinary actions;

d. Hearings and appellate reviews;

e. Quality assessment and performance improvement/peer review activities;

f. Utilization review and improvement activities;

g. Claims reviews;

h. Risk management and liability prevention activities; and

i. Other hospital, committee, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases

When requested by the Chief of Staff or Credentials Chair, or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest

A member of the Medical Staff requested to perform a Board designated Medical Staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

ADOPTED by the Medical Staff on

_____
Chief of Staff Date

_____
Credentials Chair Date

_____
Ryan Smith, CEO, Administrator Date

Approved by the Governing Body on xxxxx

_____
Board President Date

_____
Board Secretary Date

Revised:
May 2005; January 2008; January 2009; February 2009; September 2013; March 2014; December 2014; December 2015; September 2016; November 2018; February 2019; November 2019; August 2020; September 2021

Medical Staff Office
4300 Bartlett Street
Homer, AK 99603
(907) 235-0849
medstaffoffice@sphosp.org

MEMO

To: South Peninsula Hospital Board of Directors

From: Medical Staff Office

Date: September 15, 2025

Re: South Peninsula Hospital and Long Term Care Facility – Medical Staff Bylaws

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Dr. Paul Murphree of Chartis/Greeley assisted the medical staff leadership with review and revision of the Medical Staff Bylaws, which had not undergone comprehensive review since 2021. Dr. Murphree visited SPH to assist with this process, and attended a Medical Executive Committee (MEC) meeting to help present the revisions and answer any questions. On July 9, 2025 the South Peninsula Hospital MEC approved the revised draft of the South Peninsula Hospital and Long Term Care Facility – Medical Staff Bylaws.

On August 9th, 2025 the revised draft was presented to the full medical staff via email, soliciting feedback. Multiple members offered suggestions and questions. Edits were made, vetted by Dr. Murphree, and the final version was approved by the MEC on September 5, 2025.

At the General Medical Staff meeting on September 10, 2025 the membership as a whole voted in favor of the revised South Peninsula Hospital and Long Term Care Facility – Medical Staff Bylaws by a 2/3 supermajority.

Per the Medical Staff Bylaws, Section 9. Review, Revision, Adoption and Amendment

9.2.3 Approval Process.

a. The bylaws amendment will be voted on at a general Medical Staff meeting. For approval, there must be a two-thirds (2/3rds) supermajority vote of the votes cast, when a quorum is present.

b. Amendments so adopted shall be effective when approved by the Board.

Below is a Summary of Change for South Peninsula Hospital Bylaws:

4/29/2025, 5/23/25, 6/5/25, 8/9/25, 9/4/25

Note: Minor edits for clarity, spelling, punctuation, etc. are not specifically addressed here.

The items in red were added due to feedback provided by the Medical Staff and not included in the original draft of this document.

Part I: Governance

Added Definitions for CMO, COO, Corrective Actions, Investigation, Privileges, and MEC

2.6.4: Clarifying that the Chief Medical Officer (CMO) role is an Administrative leader and not a Medical Staff leader

2.6.6 Reporting a newly filed malpractice claim. Added : "in writing"

3.1: These categories are "membership" categories

3.1.1: Membership categories: Updated

4.2.2 Add SPH Board to list of exclusions for being an officer of the Medical Staff

4.3: Minor wording changes and added "electronic" means of voting & generalized rank choice voting.

4.4 Term limits for each MEC position, except Peer Review Committee representative.

4.6: Add that vacancies other than Chief of Staff (COS) will follow the same election process as per section 4.3.

4.7: Adding process when COS has a conflict of interest.

6.2: Add CNO, CMO, COO, and CFO as ex officio/non-voting members of MEC.

6.2.1.b Clarified composition of MEC to align with the BOD Bylaws.

7.1 Adding specifics to the described process of notification.

7.4.3: PRC : Adding quorum definition that allows non-final determinations to still be reviewed if at minimum 2 members are present

7.7: Robert's Rules of Order is fine, but realize that only occurs if the Chair decides it is needed.

Part II: Investigations, CA, Hearing, etc.

3.1.13: indented this item to align with "automatic" actions. This section allows the MEC to discuss the automatic action and "Add" to the automatic action another recommendation. For example, someone didn't participate in a mandatory influenza vaccine and furthermore started on a public campaign to stop all influenza vaccine. You might consider additional actions based on their unscientific approach to vaccinations.

7.7 removing clinical psychologist and making this section more "generic"

Part III Credentials

2.2 Add NBPAS as a recredentialing board.

2.2.13 removed since you don't have clinical psychologist now.

2.4 Added qualifications for membership w/o Privileges

4.2.1 & 4.2.2e removed CME tracking & verification

5.6.1 updated APP Students, Residents or fellows in Training language

5.8 added the Credentials Chair to the list of those who must provide recommendations for temp privileges

Organization and Functions Manual

1.3.2 Replace w/Peer Review Policy.

2.4 Remove details regarding composition of the Peer Review Committee and refer to policy. This allows for easier adjustment to the structure of the Peer Review Committee.

3.3.1 define an "Expedited Credentialing Process" that can reduce the need for "Temporary Privileges" It requires 2 board members to approve a Category 1 after MEC recommendation and Credentialing Chair (on the MEC).

BYLAWS
SOUTH PENINSULA HOSPITAL, INC.

ARTICLE I - NAME AND OBJECTIVES

Section 1.

The name of this corporation shall be South Peninsula Hospital, Inc., and its mailing address shall be 4300 Bartlett Street, Homer, Alaska 99603.

Section 2.

The name of the Board shall be the South Peninsula Hospital Board of Directors, and shall be referred to in these Bylaws as the Hospital Board.

Section 3.

The objective of the Hospital Board shall be to construct, maintain, and operate a hospital and authorized services in accordance with the laws and regulations of the State of Alaska and in fulfillment of our responsibility to the taxpayers and citizens of the South Kenai Peninsula Hospital Service Area. The Hospital Board shall be responsible for the control and operation of the Hospital and authorized services including the appointment of a qualified medical staff, the conservation and use of hospital monies, and the formulation of administrative policy.

ARTICLE II - MEETINGS

Section 1. Regular Meetings.

The Hospital Board shall hold regular meetings with a minimum of ten (10) meetings a year. Meetings shall be held at South Peninsula Hospital or such other place as may be designated, or virtually through telephonic or other electronic means

Section 2. Special Meetings.

Special meetings may be called by the President, Vice-President, Secretary, or Treasurer, at the request of the Administrator, Chief of Staff, or three Board members. Members shall be notified of special meetings, the time, place, date, and purpose of said meeting. Notice will be given verbally or by email. A minimum of five days' notice shall be given to members except in the event of an emergency. Notice will be provided to borough clerk and posted on SPHI website.

Section 3. Quorum.

A quorum for the transaction of business at any regular, special, or emergency meeting shall consist of a majority of the seated members of the Hospital Board, but a majority of those present shall have the power to adjourn the meeting to a future time. Attendance may be in person through telephonic or other electronic means.

Section 4. Minutes.

All proceedings of meetings shall be permanently recorded in writing by the Secretary and distributed to the members of the Hospital Board and ex-officio members. Copies of minutes will be posted on the SPHI website.

Section 5. Reconsideration:

A member of the board of directors who voted with the prevailing side on any issue may move to reconsider the board's action at the same meeting or at the next regularly scheduled meeting. Notice of reconsideration can be made immediately or made within forty-eight hours from the time of the original action was taken by notifying the president or secretary of the board.

Section 6. Annual Meeting.

The annual meeting of the Board of South Peninsula Hospital, Inc. shall be held in January, at a time and place determined by the Board of Directors. The purpose of the annual meeting shall include election of officers and may include appointment of Board members.

ARTICLE III - MEMBERS

Section 1.

Qualifications.

1. Board members must be at least 21 years old and a resident of the South Kenai Peninsula Hospital Service Area (" Service Area") of the Kenai Peninsula Borough; except that as many as three directors may reside outside the Service Area. The Board may establish other qualifications for Directors by resolution or policy. The Board may also establish criteria for the composition of the Board as a whole by resolution or policy, provided that at least 51% of the Board must be independent directors. By resolution or policy, the Board may impose restrictions on the eligibility of and guidelines for directors, including non-independent directors such as Medical Staff Members with privileges, to serve as committee members on Board committees.

2. Medical Staff Members with privileges to practice in corporation facilities, including employees of the corporation, are eligible to serve on the Board of Directors, provided that the number of such Medical Staff Members concurrently serving on the Board

shall not exceed two (2) directors at any time, and the number of non-physician medical staff members shall not exceed one (1) director at any time. Medical Staff Board Members will be recused from influencing the following Board decisions:

- Physician compensation including pay for performance considerations
- CEO compensation
- Approval of the annual audit
- Legal matters of which the Physician or a family member is the subject

· Medical Staff Board Members cannot serve on or have family relationships with members of the Physician Peer Review Committee

3. Except as provided in Section 2.B. employees of the corporation's facilities may not serve as Board members while so employed or within one year after termination of employment.

The number or Directors of this corporation shall be nine (9) to eleven (11). The Board may change the number of Directors at any time by amendment to these Bylaws, but a decrease cannot have the effect of shortening the term of an incumbent Director.

Section 2.

Appointments to the Hospital Board shall be made by the Hospital Board with an affirmative vote of the majority of the Board. Term of office shall be three (3) years with appointments staggered so that at least three members' terms will expire each year on December 31. Members may be reappointed by an affirmative vote of the majority of the Board. Election shall be by secret ballot. Elections may be held by any electronic means that provides the required anonymity of the ballot.

Section 3.

Vacancies created by a member no longer able to serve shall be filled by the procedure described in Section 2 for the unexpired term. Any member appointed to fill a vacant seat shall serve the remainder of the term for the seat the member has been appointed to fill.

Section 4.

Any Hospital Board member who is absent from two (2) consecutive regular meetings without prior notice may be replaced. In the event of sickness or circumstances beyond the control of the absent member, the absence may be excused by the President of the Board or the President's designee. Any Board member who misses over 50% of the Board meetings during a year may be replaced.

Section 5.

Censure of, or removal from the Board of any member shall require a 2/3 affirmative vote of the remaining Board members, excluding the board member in question.

Section 6.

No member shall commit the Hospital Board unless specifically appointed to do so by the Hospital Board, and the appointment recorded in the minutes of the meeting at which the appointment was made.

Section 7.

Hospital Board members will receive a stipend according to a schedule adopted by the board and outlined in Board Policy SM-12 Board Member Stipends.

ARTICLE IV - OFFICERS

Section 1.

The officers of the Hospital Board shall be a President, Vice-President, Secretary, and Treasurer.

Section 2.

At the annual meeting in the month of January each even year, the officers shall be elected, all of whom shall be from among its own membership, and shall hold office for a period of two years.

Section 3.

President. The President shall preside at all meetings of the Hospital Board. The President may be an appointed member to any committee and shall be an ex-officio member of each committee.

Section 4.

Vice-President. The Vice-President shall act as President in the absence of the President, and when so acting, shall have all of the power and authority of the President.

Section 5.

In the absence of the President and the Vice-President, the members present shall elect a presiding officer.

Section 6.

Secretary. The secretary shall be responsible for the minutes of the meeting, act as custodian of all records and reports, ensure posting of the agenda and minutes on the website, ensure that notification is provided to the Kenai Peninsula Borough for any changes to board membership or officer assignments, and other duties as set forth by the Hospital Board. These duties shall be performed in conjunction with SPH Hospital Staff assigned to assist the Board.

Section 7.

Treasurer. The Treasurer shall have charge and custody of, and be responsible to the Hospital Board for all funds, properties and securities of South Peninsula Hospital, Inc. in keeping with such directives as may be enacted by the Hospital Board.

ARTICLE V - COMMITTEES

Section 1.

The President shall appoint the number and types of committees consistent with the size and scope of activities of the hospital. The committees shall provide advice or recommendations to the Board as directed by the President. The President may appoint any person including, but not limited to, members of the Board to serve as a committee member. Only members of the Board will have voting rights on any Board committee. All appointments shall be made a part of the minutes of the meeting at which they are made.

Section 2.

Committee members shall serve without remuneration. Reimbursement for out-of-pocket expenses of committee members may be made only by hospital Board approval through the Finance Committee.

Section 3.

Committee reports, to be presented by the appropriate committee, shall be made a part of the minutes of the meeting at which they are presented. Substance of committee work will be fully disclosed to the full board.

ARTICLE VI - ADMINISTRATOR

Section 1.

The Administrator shall be selected by the Hospital Board to serve under its direction and be responsible for carrying out its policies. The Administrator shall have charge of and be responsible for the administration of the hospital.

Section 2.

The Administrator shall supervise all business affairs such as the records of financial transactions, collection of accounts and purchases, issuance of supplies, and to ensure that all funds are collected and expended to the best possible advantage. All books and records of account shall be maintained within the hospital facilities and shall be current at all times.

Section 3.

The Administrator shall prepare an annual budget showing the expected receipts and expenditures of the hospital.

Section 4.

The Administrator shall prepare and submit a written monthly report of all expenses and revenues of the hospital, preferably in advance of meetings. This report shall be included in the minutes of that meeting. Other special reports shall be prepared and submitted as required by the Hospital Board.

Section 5.

The Administrator shall appoint a Medical Director of the Long Term Care Facility. The Medical Director shall be responsible for the clinical quality of care in the Long Term Care Facility and shall report directly to the Administrator.

Section 6.

The Administrator shall serve as the liaison between the Hospital Board and the Medical Staff.

Section 7.

The Administrator shall provide a Collective Bargaining Agreement to the Hospital Board for approval.

Section 8.

The Administrator shall see that all physical properties are kept in a good state of repair and operating condition.

Section 9.

The Administrator shall perform any other duty that the Hospital Board may assign.

Section 10.

The Administrator shall be held accountable to the Hospital Board in total and not to individual Hospital Board members.

ARTICLE VII - MEDICAL STAFF

The Hospital Board will appoint a Medical Staff in accordance with these Bylawsand the Bylaws of the Medical Staff approved by the Hospital Board. The Medical Staff will operate as an integral part of the hospital corporation and will be responsible and accountable to the Hospital Board for the discharge of those responsibilities delegated to it by the Hospital Board from time to time. The delegation of responsibilities to the Medical Staff under these Bylaws or the Medical Staff Bylaws does not limit the inherent power of the Hospital Board to act directly in the interests of the Hospital.

Section 1.

The Hospital Board has authorized the creation of a Medical Staff to be known as the Medical Staff of South Peninsula Hospital. The membership of the Medical Staff will be comprised of all practitioners who are eligible under Alaska state law and otherwise satisfy requirements established by the Hospital Board. Membership in this organization shall not be limited to physicians only. Membership in this organization is a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. The Medical Staff organization, and its members will be responsible to the Hospital Board for the quality of patient care practiced under their direction and the Medical Staff will be responsible for the ethical and clinical practice of its members.

The Chief of Staff will be responsible for regular communication with the Hospital Board.

Section 2.

The Hospital Board delegates to the Medical Staff its responsibility to develop Bylaws, and Rules and Regulations for the internal governance and operation of the Medical Staff. Neither will be effective until approved by the Hospital Board.

The following purposes and procedures will be incorporated into the Bylaws and Rules and Regulations of the Medical Staff:

1. The Bylaws and Rules and Regulations of the Medical Staff will state the purposes, functions and organization of the Medical Staff and will set forth the policies by which the Professional Staff exercises and accounts for its delegated authority and responsibilities.
2. The Medical Staff Bylaws will require adherence to an identified code of behavior within the Hospital. The Bylaws will state that the ability to work harmoniously and cooperatively with others is a basic requirement for initial appointment and

reappointment. Such Bylaws will state that appointment and reappointment is subject to compliance with Medical Staff Bylaws and Hospital Board Bylaws.
3. The Medical Staff Bylaws or Rules and Regulations will clearly define a regular method of quality assessment if not established by Hospital Board policy.

Section 3.

The following tenets will be applicable to Medical Staff membership and clinical privileges:

1. The Hospital Board delegates to the Medical Staff the responsibility and authority to investigate and evaluate matters relating to Medical Staff membership, clinical privileges, behavior and disciplinary action, and will require that the Medical Staff adopt, and forward to the Hospital Board, specific written recommendations with appropriate supporting documentation that will allow the Hospital Board to take informed action when necessary.
2. Final actions on all matters relating to Medical Staff membership, clinical privileges, behavior and disciplinary action will generally be taken by the Hospital Board following consideration of Medical Staff recommendations. However, the Hospital Board has the right to directly review and act upon any action or failure to act by the Medical Staff if, in the opinion of the Hospital Board, the Medical Staff does not or is unable to carry out its duties and responsibilities as provided in the Medical Staff Bylaws.
3. In acting on matters involving granting and defining Medical Staff membership and in defining and granting clinical privileges, the Hospital Board, through the Medical Staff's recommendations, the supporting information on which such recommendations are based, and such criteria as are set forth in the Medical Staff Bylaws. No aspect of membership nor specific clinical privileges will be limited or denied to a practitioner on the basis of sex, race, age, color, disability, national origin, religion, or status as a veteran.
4. The terms and conditions of membership on the Medical Staff and exercise of clinical privileges will be specifically described in the notice of individual appointment or reappointment.
5. Subject to its authority to act directly, the Hospital Board will require that any adverse recommendations or requests for disciplinary action concerning a practitioner's Medical Staff appointment, reappointment, clinical unit affiliation, Medical Staff category, admitting prerogatives or clinical privileges, will follow the requirements set forth in the Medical Staff Bylaws.
6. From time to time, the Hospital Board will establish professional liability insurance requirements that must be maintained by members of the Medical Staff as a condition of membership. Such requirements will be specific as to amount and kind of insurance and must be provided by a rated insurance company acceptable to the Hospital Board.

ARTICLE VIII - AUTHORIZATION OF INDEBTEDNESS

Section 1. Indebtedness.

It shall require seventy five percent (75%) of the entire Hospital Board to commit funds beyond current income, cash available, and appropriations of the current budget.

ARTICLE IX - AMENDMENTS

Section 1.

The Bylaws may be altered, amended, or repealed by the members at any regular or special meeting provided that notice of such meeting shall have contained a copy of the proposed alteration, amendment or repeal and that said proposed alteration, amendment, or repeal shall be read at two meetings prior to a vote.

Section 2.

An affirmative vote of seventy-five percent (75%) of the entire membership shall be required to ratify amendments, alterations or repeals to these Bylaws.

Section 3.

These Bylaws shall be reviewed at the annual meeting.

ARTICLE X - ORDER OF BUSINESS

Section 1.

The order and conduct of business at all meetings of the Hospital Board shall be

consistent with the following procedure.

An agenda will be prepared and posted prior to each regular meeting, special meeting, or committee meeting, stating the intended topics of discussion/review at the meeting.

Except in the case of an emergent topic, no additional topics will be included in the agenda once it has been finalized and posted.

The agenda will be approved at the beginning of each meeting using the motion, second, vote process, and may include amendments to the order of business only.

If a Board Member has a conflict of interest with any item on the consent agenda, that item will be removed for individual consideration using the amendment procedure above.

Business will be conducted using a motion, second, discussion and vote format. When reviewing and discussing resolutions, amendments may be proposed using the same format and must be approved or declined before moving forward with the final approval of the resolution.

In order to keep track of the discussion, only one amendment may be introduced, discussed and voted on at a time, and "friendly amendments" should not be considered. Clear each proposed amendment and make additional amendments if desired.

~~governed by Roberts Rules of Order Revised, except when provided otherwise in these Bylaws~~.

ARTICLE XI - INDEMNIFICATION

Section 1.

The corporation shall indemnify every person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the corporation) by reason of the fact that he is or was a board member, director, officer, employee or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust of other enterprise, against expenses (including attorneys' fees), judgment, fines and amounts paid in settlement actually and reasonably incurred by him in connection with such action, suit or proceeding if he acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the corporation and, with respect to any criminal action or proceeding, had no reasonable cause to believe his conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contender or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he reasonably believed to be in or not opposed to any criminal action or proceeding, had reasonable cause to believe that his conduct was unlawful.

Section 2.

The corporation shall indemnify every person who has or is threatened to be made a party to any threatened, pending or completed action or suit by or in the right of the corporation to procure a judgment in its favor by reason of the fact that he is or was a board member, director, officer, employee or agent of the corporation, partnership, joint venture, trust of other enterprise against expenses (including attorneys' fees) actually and reasonably incurred by him in connection with the defense or settlement of such action or suit if he acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the corporation except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been adjudged to be liable for negligence or misconduct in the performance of his duty to the corporation unless and only to the extent that the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all circumstances of the case, such person is fairly and reasonably entitled to indemnify for such expenses which such court shall deem proper.

Section 3.

To the extent that a board member, director, officer, employee or agent of the corporation has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in subsections 1 and 2 hereof, or in defense of any claim, issue or matter therein, he shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred by him in connection therewith.

Section 4.

Any indemnification under subsections 1 and 2 hereof (unless ordered by a court) shall be made by the corporation only as authorized in the specific case upon a determination that indemnification of the board member, director, officer, employee or agent is proper in the circumstances because he has met the applicable standard of conduct set forth in subsections 1 and 2 hereof. Such determination shall be made (a) by the Board of Directors by a majority vote of a quorum consisting of directors who were not parties to such action, suit or proceedings, or (b) if such quorum is not obtainable, or even if obtainable, a quorum of disinterested directors so directs, by independent legal counsel in a written opinion.

Section 5.

Expenses incurred in defending a civil or criminal action, suit, or proceeding may be applied by the corporation in advance of the final disposition of such action, suit or proceeding as authorized by the Board of Directors in the manner provided in subsection 4 upon receipt of any undertaking by or on behalf of the board member, director, officer, employee or agent, to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the corporation as authorized in this section.

Section 6.

The indemnification provided by this Article shall not be deemed exclusive of any other rights to which those indemnified may be entitled under any resolution adopted by the members after notice, both as to action in his official capacity and as to action in another capacity while holding office, and shall continue as to a person who has ceased to be a board member, director, officer, employee or agent and shall inure to the benefit of the heirs, executors and administrators of such a person.

- Adopted by the South Peninsula Hospital Board of Directors, January 29, 2025.

- Aaron Weisser, President

- Mary E. Wythe, Secretary

South Peninsula Hospital
Hospital Board of Directors Balanced Scorecard Report
4th Quarter FY 2025 *(April, May, June)*

Overall Indicators	Q4 FY25	Target	Note
Care Compare Overall Hospital Star Rating	N/A	5	Mortality, Safety of Care, Readmission, Patient Experience, Timely & Effective Care
Care Compare Overall Nursing Home Star Rating	5	5	Staffing, Health Inspections, Quality Measures
Care Compare Home Health Quality Rating	3	5	Activities of Daily Living, Symptoms, Harm, Hospitalization, Value of Care

Clinical & Service Excellence

Using evidence-based practices, South Peninsula Hospital is dedicated to achieving consistent and demonstrated excellence in clinical quality and safety.

Quality of Care / Patient Safety	Q4 FY25	Target	Note
Severe Sepsis & Septic Shock Care	90%	> 75%	***CMS Hospital Compare: 79%***
Percentage *of patients who received appropriate care for sepsis and/or septic shock.*			Passed 9 of 10 cases (blood cultures after antibiotics)
Stroke Care	N/A	> 75%	***CMS Hospital Compare: 67%***
Percentage of patients who receive CT/MRI within 45 minutes of arrival to ED w/stroke symptoms.			No cases per CMS (5-49 minutes on stroke alerts)
Median Emergency Room Time	162	< 180min	***CMS Hospital Compare: 126 min***
Average minutes spent in department before leaving the Emergency Department.			Average throughput time of all ED visits (CMS allows for certain exclusions).
Colonoscopy Follow-up	100%	> 75%	***CMS Hospital Compare: 100%***
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy.			
Patient Fall Rate (AC)	4	< 5	**# of patient falls / # patient days x 1000**
Measures the number of patient falls per 1,000 patient days.			*4 falls, one with major injury*
Medication Errors	0	0	
Number of patient medication errors that cause harm. *(Level E on the NCC MERP Index)*			*(Tracking through occurrence reporting system.)*
Never Events	1	0	
Unexpected occurrence involving serious injury or death.			*Fall with major injury referenced above*

Independent Ambulation (HH)	**74%**	**> 75%**	
Percentage of home health patients demonstrating improvement with ability to ambulate more independently.			*(Tracked through OASIS Reporting.) No patients worsened.*
Independent Oral Medication (HH)	**76%**	**> 75%**	
Percentage of home health patients demonstrating improvement with ability to take oral medications more independently.			*(Tracked through OASIS Reporting.) No patients worsened.*
Pressure Ulcers (LTC)	**0**	**< 3**	
Number of residents who develop pressure ulcers after admission.			*(Tracked through Minimum Data Set Reporting.)*
Primary Care MIPS Pathways	**70%**	**> 75%**	**Scoring tabulated as a running, annual score.**
CMS Merit-Based Incentive Payment System *(MIPS)* for outpatient clinics.			Special focuses: cervical cancer screening, specialist referrals, high blood pressure, hemoglobin A1c, medication reconcilation, fall risk

Patient & Resident Experience

Patient Satisfaction Through Press Ganey (PG)	**Q4 FY25**	**Target**	
Inpatient Percentile	**63rd**	**75th**	Survey Responses: 32
Measures the overall satisfaction of inpatient pts. respondents.			
Outpatient Percentile	**34th**	**75th**	Mean Score: 94.48
Measures the overall satisfaction of outpatient pts. respondents.			
Emergency Department Percentile	**92nd**	**75th**	Mean Score: 93.86
Measures the overall satisfaction of emergency pts. respondents.			
Medical Practice Percentile	**59th**	**75th**	Mean Score: 94.44
Measures the overall satisfaction of pts. respondents at SPH Clinics.			
Ambulatory Surgery (AS) Percentile	**25th**	**75th**	Top Box: 82.35
Measures the overall satisfaction of AS pts. respondents.			
Home Health (HH) Percentile	**43rd**	**75th**	*Running 12 months due to low quarterly returns.
Measures the overall satisfaction of HH pts. respondents.			

Information System Solutions	Q4 FY25	Target	Note
Eligible Hospital (EH) Promoting Interoperability	**79**	**≥ 60**	**CMS score 60 and above = pass**
Hospital-based measures for inpatient and observation stays.			Focuses include: electronic prescribing accuracy and safety, health information exchange topics, patient access to electronic records
Eligible Provider (EP) - Promoting Interoperability (Group)	**100%**	**> 95%**	**Target quarterly for annual score**
Merit Based Incentive Payment System Promoting Interoperability score. *(MIPS tracking is in Athena)*			Special focuses: patient electronic access to health information, electronic referrals, electronic prescriptions
IT Security Awareness Training Complete Rate	**78%**	**> 95%**	
% of employees who have completed assigned security training			2020 Training videos sent; 1572 were completed.
Phishing Test Pass Rate	**98%**	**> 95%**	
% of Phishing test emails that were not failed.			3411 Test phishing emails sent; 71 links were clicked.

Medical Staff Alignment

South Peninsula Hospital desires to be an employer and/or provider of choice for medical staff practitioners by fostering an atmosphere of continuous collaboration.

Provider Alignment	2024	Target	Note
Provider Satisfaction Percentile	**85th**	**75th**	
Measures the satisfaction of physician respondents as indicated by Press Ganey physician survey results. Measured as a percentile.			Result of provider survey 2024

Employee Engagement

South Peninsula Hospital desires to be an employer of choice that offers our staff an opportunity to make positive impact in our community.

Staff Alignment	2024	Target	Note
Employee Satisfaction Percentile	**60th**	**75th**	
Measures the satisfaction of staff respondents as indicated in Press Ganey staff survey results Measured as a percentile.			Result of employee survey 2024

Workforce	Q4 FY25	Target	Note
Turnover: All Employees	**5%**	**< 5%**	
Percentage of all employees separated from the hospital for any reason			35 Terminations / 645 Total Employees
Turnover: Voluntary All Employees	**3%**	**< 4.75%**	
Measures the percentage of voluntary staff separations from the hospital			20 Voluntary Terminations / 645 Total Employees
First Year Total Turnover	**5%**	**< 7%**	
Measures the percentage of staff hired in the last 12 months and who separated from the hospital for any reason during the quarter.			8 New Staff Terminated 36 Total New Hires
Contract Utilization	**23**	**< 20**	
Measure average number of contract staff utilized.			CNA, CST, MLT, PT, RN, RT

Financial Health

SPH is financially positioned to support our dedication to the Mission, Vision and Values, and our continued investment in our employees, medical staff, physical plant and equipment.

Financial Health	Q4 FY25	Target	Note
Operating Margin	**1%**	**-2%**	
Measures the surplus (deficit) of operating income over operating expenses as a percentage of net patient service revenue for the quarter.			Target is based on budgeted operating margin for the period.
Adjusted Patient Discharges	**1082**	**991**	**Total Discharges: # 157 *(Acute, OB, Swing, ICU)***
Measures the number of patient discharges adjusted by inpatient revenues for the quarter.			Adjusted Patient Days = [Inpatient Days(Excludes Nursery)] X [Gross Patient Revenue/Gross Inpatient Revenue] Target Discharges 150
Net Revenue Growth	**0%**	**-8%**	
Measures the percentage increase *(decrease)* in net patient revenue for the quarter compared to the same period in the prior year.			Target is based on budgeted net patient service revenue for the period compared to net patient service revenue for the same period in prior yr.
Full Time Equivalents *(FTEs)* per Adjusted Occupied Bed	**7.9**	**9.1**	
Measures the average number of staff FTEs per adjusted occupied bed for the quarter.			Target is based on budgeted paid hours *(FTE)* divided by *(budget gross patient revenue/budget gross inpatient rev)* X budgeted average daily census for the quarter.

Net Days in Accounts Receivable	**58**	**55**	
Measures the rate of speed with which the hospital is paid for health care services.			
Cash on Hand	**76**	**90**	**93 Total Days Cash on Hand, Operating +Unobligated PREF**
Measure the actual unrestricted cash on hand (excluding PREF and Service Area) that the hospital has to meet daily operating expenses.			Cash available for operations based average daily operating expenses during the quarter less depreciation for the quarter.
Uncompensated Care as a Percentage of Gross Revenue	**2%**	**2-3%**	
Measures bad debt & charity write offs as a percentage of gross patient service revenue			Target is based on industry standards & SPH Payer Mix Budgeted total is 2.4% Expected range of 2-3%
Average Age of Plant	**10.8**	**8**	
Average age of assets used to provide services			Target is based on hospital optimal age of plant.
Intense Market Focus to Expand Market Share	**Q4 FY25**	**Target**	**Note**
Outpatient Revenue Growth	**0%**	**-3%**	
Measures percentage increase (decrease) in outpatient revenue for the quarter, compared to the same period in the prior year.			Target is based on budgeted outpatient revenue for the period compared to outpatient revenue for the same period prior yr.
Surgical Case Growth	**9%**	**24%**	
Measures the increase *(decrease)* in surgical cases for the quarter compared to the same period in the prior year.			Target is based on budgeted surgeries above actual from same quarter prior yr.

PURPOSE:
Guidelines for the management of the election of board members and term limits for board officers.

DEFINITION(S):
N/A

POLICY:
A. Board Member Election Process
   1. The Governance Committee (the Committee) will facilitate the election of new board members and commence the electoral process no later than September of each year.
   2. At least forty-five days prior to a sitting board member's term of office expiring, the ~~Membership~~ Governance ~~Committee~~ Chair will send a notice confirming the term ending and the procedures to apply for re-appointment. The board member will have fifteen days to respond ~~to the Membership Committee~~. Simultaneously, the ~~Governance~~ Committee will have ~~place~~ a display ad placed in the local papers, and a notification will be posted on the landing page of the SPH website, inviting members of the Service Area to apply to serve on the Board of Directors. Board members are also encouraged to provide recommendations to the ~~Membership/Governance~~ Committee for potential candidates and the ~~Membership~~ Committee will reach out to those potential members.
   3. Each Candidate will complete an application. Two references will be required for ~~successful~~ new board applicants to be considered for appointment. Exceptions will be made for applicants who are well known to an existing board member(s) if that member(s) is able to provide a positive reference for the applicant. Reference checks will be completed by the ~~Governance~~ Committee.
   4. Applications will be reviewed by the ~~Membership~~ Committee.
   5. Interviews will be coordinated virtually for selected candidates, and all board members will be invited to attend the interview.
   6. The Committee will prepare a list of recommended candidates for the consideration of the Board.
   7. ~~Two references will be required for successful board applicants to be considered for appointment. Exceptions will be made for applicants who are well known to an existing board member(s) if that member(s) is able to provide a positive reference for the applicant. Reference checks will be completed by the Governance Committee~~. Board member terms will be three years. Vacancies created by a member no longer able to serve shall be filled for the remainder of the unexpired term, as provided for in the bylaws.

B. Vacancies
   1. Each candidate recommended by the Committee will be reviewed in Executive Session. Incumbents will leave the room when the discussion is concerning their application.
   2. Candidates will be voted on by secret ballot at a regularly scheduled Executive Session and the appointment of selected candidates will be ratified by the Board of Directors in an Open Session.
   3. After board members are seated, the Kenai Peninsula Borough will be notified of continuing or newly appointed members in accordance with the Operating Agreement.

C. Officer Terms
   1. Board Officers (President, Vice President, Treasurer, and Secretary) will serve ~~two year~~two-year terms, with a maximum of two consecutive terms. Exceptions may be made in special circumstances, which would require a vote of the board.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
N/A

CONTRIBUTORS: Board of Directors

South Peninsula Hospital	**SUBJECT:** Board Orientation and Continuing Education	**POLICY #:** SM-10 **Page 1** of **1**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** 8/27/08 **Effective:** 9/24/25
Revised: 4/2019; 11/20/19 **Reviewed:** 9/24/25		**Revision Responsibility:** Board of Directors

PURPOSE:
Requirements for Board member orientation and continuing education.

DEFINITION(S):
N/A

POLICY:
A. The Board of Directors recognizes the importance of continuing education for Board members, and the benefits of attending workshops and seminars to further Board effectiveness.
B. Pursuant to the Operating Agreement, the SPHI Board will establish a Board Orientation and Continuing Education Program. Per section 17 b 1 of Operating Agreement, the Board will report annually on compliance with the Program to the Contract Administrator. The Board Orientation plan is contained in Policy SM-07. An annual Education budget of hours and dollars [BW1]will be established based on the plan during the Operating Budget Preparation Cycle.
C. Every Board member will be required to attend one educational conference at least every other year. The Alaska State Hospital and ~~Nursing Home~~Healthcare Association (~~ASHNHA~~AHHA) Annual Conference and the American Hospital Association's Rural Health Care Leadership Conference are strongly encouraged[BW2].
D. Attendance of other affiliated conferences that fit the training recommendations in Appendix A, may be approved by the Board ~~Chair~~President at the request of interested participants.
E. Due to the expense of attending out of town educational opportunities, attendance will be limited to Board members who are in good standing and have 12 months or more left of their term unless they indicate their intent to renew their term. Attendance will be ~~determined by the President of the Board of Directors~~coordinated through Hospital Administration.[BW3]
F. Possible subject matter areas for Board Education include the items in Appendix A to this Policy. The annual content will vary based on Board needs at the time of the Planning Cycle, but will, in general, contain information from the Subject Matter Areas.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
A. South Peninsula Hospital's Values & Behaviors as adopted by the Board of Directors
B. Operating Agreement for South Peninsula Hospital with Kenai Peninsula Borough, 2020
C. Appendix A – SM-10 Board Orientation and Continuing Education Subject Matter Areas

CONTRIBUTOR(S):
Board of Directors

Appendix A
SM-10 Board Orientation and Continuing Education
Subject Matter Areas

1. Credentialing
2. The Basic Roles and Responsibilities of Today's Board
3. This Hospital: (Services, Management, and Administration)
4. Fiduciary Responsibilities (Hospital Finances and Budgets)
5. The Board's Leadership Role
6. The Board's Role in Mission, Vision, and Values
7. Understanding Key Stakeholders (Regulatory Entities; the Community; etc.)
8. Defining the Organization's Future and Strategically Managing for the Future
    a. Strategic Planning
    b. Trends in Healthcare
9. Rural Hospital Issues
10. Board Effectiveness and Orientation
    a. Analyzing performance
    b. Role of Board committees
    c. Improving performance
11. The Board's Role in Quality (Patient Safety & Quality)
12. The Board's Relationship with the:
    a. CEO
    b. Medical Staff
    c. Workforce
13. The Board's Role in Managing Change
14. Conflict Management at the Board Level
15. Medical and Information Technologies
16. Trustees as Health Advocates
17. Critical Access Hospital

Investigation of Chief Executuve Officer (the CEO) ~~and Hospital Leadership~~ Misconduct

Effective Date: [Insert Date]

Review Date: [Insert Date]

Approved by: [Board Name/Board Chair]

Purpose

~~This policy~~To establish~~es~~ a clear and transparent process for investigating allegations of misconduct involving the CEO ~~and other hospital leadership~~ to ensure accountability, integrity, and the continued trust of the employees and the community in the hospital's operations.

Scope

This policy applies to the CEO. ~~and~~ Concerns regarding all other members of the hospital executive leadership team, ~~including but not limited to the Chief Financial Officer (CFO), Chief Operating Officer (COO), and other executive positions~~will be managed through the hospital's established human resources complaint processes.

Policy Statement

The hospital is committed to maintaining high ethical standards and compliance with all applicable laws and regulations. Any allegations of misconduct by the CEO ~~or hospital leadership~~ will be taken seriously and investigated promptly and thoroughly.

Definitions

- **Misconduct:** Any unethical or illegal behavior, including but not limited to fraud, harassment, discrimination, gross negligence, or violation of hospital policies.
- **Investigating Committee:** ~~A group appointed by the Board to oversee the investigation process.~~The composition of the investigating committee will be determined following a review of the complaint to determine the appropriate level of representation required.

Procedure

1. **Reporting Allegations**
    - Allegations of misconduct may be reported by any employee, board member, or stakeholder to the Board Chair or a designated member of the Board.
    - ~~Reports can be made anonymously, and r~~Retaliation against individuals who report in good faith is strictly prohibited.
    - Reports will be reduced to writing either by the person filing the complaint, or the person responsible for receiving the complaint.
    - All information received will be held in confidence to the extent possible while completing an investigation.

2. **Initial Review**
    - Upon receiving a report, the Board Chair will conduct an initial review to determine whether the allegations warrant further investigation.
    - If the Board Chair is implicated, the Vice Chair will assume this responsibility.
3. **Formation of Investigating Committee**
    - If an investigation is warranted, the Board Chair will form an Investigating Committee, which may include:
        - Board members
        - Legal counsel (if necessary)
        - External investigators (if deemed appropriate)
4. **Investigation Process**
    - The Investigating Committee will conduct a thorough investigation, which may include:
        - Interviews with the complainant, witnesses, and the accused
        - Review of relevant documents and records
        - Consultation with legal counsel as needed
    - All parties involved will be treated fairly, and confidentiality will be maintained throughout the process.
5. **Findings and Recommendations**
    - Upon completion of the investigation, the Investigating Committee will prepare a written report outlining findings and recommendations.
    - The report will be submitted to the Board for review.
6. **Board Action**
    - The Board will convene in executive session to discuss the findings and determine appropriate actions, which may include:
        - No action
        - Disciplinary action, up to and including termination
        - Further training or support for the ~~leadership~~CEO
7. **Communication**
    - The Board will communicate the outcome of the investigation to relevant parties while maintaining confidentiality as appropriate.
    - ~~A~~ If appropriate, a summary of the investigation process and outcomes may be shared with the hospital community to reinforce transparency.

Review and Amendments

This policy will be reviewed ~~annually~~ during the periodic review process and may be amended as necessary to reflect changes in laws, regulations, or best practices.

	Generative Discussions	Program/ Department Reviews	Prior Month SSE and Near Misses	Dashboard Review	Medical Staff	Mock Surveys/ Contracted Services/Licensure and Training
July		Pharmacy Safety and Admin	X	X		
August : Q	Patient Engagement Measures	Patient Engagement	X			
September: S	Backup Systems: Clinical and Infrastructure	Emergency Prep	X			
October		Radiology	X	X		
November: Q/S	Infection Control	Housekeeping Infection Prevention	X			
December: Q/S	H, HH and LTC Q Plan	Annual Quality Plans	X		Medical Staff Q Trends	
January		Inpatient	X	X		
February	No Meeting	No Meeting	No Meeting	No Meeting	No Meeting	No Meeting
March: Q/S	Root cause, Near miss and SSE process	Surgery	X		Medical Staff Patient Satisfaction Trends	
April		Engineering	X	X		
May: Q	Medical Staff Q Trends	Emergency Department	X			
June: S	MIPPS Clinics	Clinics	X		Medical Staff	
July		Lab	X	X		