**The following forms must be completed:**

1. Staff Category Request
2. Pharmacy Verification if you prescribe under DEA rules
3. Medicare/TriCare penalty statement related to billing
4. HIPAA Acknowledgment of Organized Healthcare Arrangement which precludes patients having to sign a separate acknowledgment for hospital and provider services provided at HRRMC
5. PACS Group Acknowledgment/Agreement ONLY if you will be accessing HRRMC's PACS imaging systems
6. Confidentiality Agreement

**Attachments included:**

1. Safeguarding Protected Health Information, HIP1109
2. Minimum Necessary, HIP1105
3. Code of Conduct and Professional Expectations

**Heart of the Rockies Regional Medical Center, Salida, Colorado**
**Application for Appointment to the Medical Staff**

## APPLICANT'S STAFF CATEGORY REQUEST

I hereby apply to the hospital for appointment as a member of the:

- ☐ Active
- ☐ Affiliate
  - ☐ Honorary
  - ☐ Courtesy
  - ☐ Consulting
- ☐ Temporary
  - ☐ Locum Tenens for _____
    beginning _____ and ending _____
  - ☐ Emergency for _____
    _____
    beginning _____ and ending _____
    or the care of a specific patient _____

In making this application for appointment to the medical staff of this hospital, I acknowledge that I have received and read the bylaws of the hospital and the bylaws and rules and regulations of the medical staff and I agree to be bound by the terms thereof if I am granted membership of clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff, and I further agree to abide by such hospital and medical staff bylaws and rules and regulations as may be from time-to-time enacted.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I have not requested privileges for any procedures for which I am not qualified. I am familiar with the laws of this State governing my practice and my licensure, and I pledge to abide by these laws.

SIGN HERE

_____ _____
Date Applicant's Signature

**NOTE: BE SURE TO ATTACH REQUIRED APPLICATION, COPIES OF LICENSURE, ETC. AND COMPLETED STRATIFICATION PLANS FOR THE PRIVILEGES BEING REQUESTED!**

# Heart of the Rockies Regional Medical Center
# PHARMACY VERIFICATION

In accordance with the Federal Drug Enforcement rules and regulations, I certify that I hold a current valid Certificate issued by that Agency under the following Certificate Number and for the following schedules of medications:

- Schedule 2
- Schedule 2N
- Schedule 3
- Schedule 3N
- Schedule 4
- Schedule 5

I also verify that as of the date of execution of this document, I have no pending actions or sanctions against this Certificate or in relation to any of the identified Schedules of medications.

SIGN HERE

_____

Signature

_____

Printed or Typed Name

_____

D.E.A. Certificate Number

_____

Date

# NOTICE TO PHYSICIANS

**Medicare/TriCare payment to hospitals is based in part on each patient's** principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal law.


_____

Physician's Signature

_____

Physician's Printed or Typed Name

_____

Date

**HEART OF THE ROCKIES REGIONAL MEDICAL CENTER**

**ACKNOWLEDGMENT OF ORGANIZED HEALTH CARE ARRANGEMENT**

I, _____, MD/DO, hereby agree that:

1. With respect to activities at Heart of The Rockies Regional Medical Center (HRRMC) I will be considered as part of an Organized Health Care Arrangement[1] with the Medical Center, as that term is defined at 45 C.F.R. 164.501, and will inform all patients under my care of this arrangement.

2. I have received a copy of all Medical Center policies, and will comply with these policies and federal and state laws and regulations relating to the Use and Disclosure of Individually Identifiable Health Information.

SIGN HERE

_____ _____

Physician Signature Date

SIGN HERE

_____ _____

Witness Signature Date

[1] This allows you to provide care to your patients at HRRMC under its Notice of Privacy Practices.

HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

# PACS GROUP ACKNOWLEDGMENT/AGREEMENT

_____
Physician's Printed Name

SIGN HERE

_____ ____ ____ ____
Physician's Signature Date

---

The above named practitioner agrees, as represented by their signature on this document, to be assigned privileges for utilization of the Heart of the Rockies Regional Medical Center PACS* system in order to have access to Medical Imaging exams for HRRMC patients for whom they are providing care.

It is understood and specifically acknowledged by these practitioners, as represented by their signature hereon, that all other practitioners within this same PACS user group will have unlimited access to the patient record for any patient registered to a practitioner within this PACS group.

In addition, it is understood and specifically acknowledged by these practitioners, as represented by their signature hereon, that if another practitioner, as part of the PACS user group is consulted on a specific HRRMC patient's care, all physicians with authorized privileges and part of this same PACS user group will also have access to that specific HRRMC patient's record. In kind, any physician within this PACS system at HRRMC for whom any one of this PACS user group is consulted will have access to that specific HRRMC patient's records.

In consideration therewith, each practitioner, as represented by his or her signature on this document, agrees to use or disclose the least amount of Protected Health Information ("PHI") necessary [as PHI is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")] needed to accomplish the intended purpose of a patient's care and specifically agrees to maintain the confidentiality under those same HIPAA regulatory requirements of all PHI to which each specific practitioner may be authorized to access.

*PAC- Personal Archiving Communication System

**Physician must contact HRRMC's Imaging Services Department (719-530-8218) and arrange to meet with the PACS Administrator for user name and password assignment, and for training on the equipment**

HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

P.O. Box 429
1000 Rush Drive
Salida, CO 81201
719.530.2200

# CONFIDENTIALITY AGREEMENT
# MEDICAL STAFF

*Applies to all members of Heart of the Rockies Regional Medical Center (HRRMC) Medical Staff.*

It is the responsibility of all members of the HRRMC Medical Staff to maintain the privacy, security and confidentiality of patient, employee, financial and business information. As persons authorized to access confidential electronic, written and oral information, Medical Staff members are required to comply with HIPAA and other state and federal health care privacy, security and confidentiality laws and regulations.

**Confidential Protected Health Information (PHI) includes but is not limited to the following:**

- Any individually identifiable health information that is created or received by a health care provider that relates to (i) the physical or mental health or condition of an individual, (ii) the provision of health care to an individual, or (iii) the payment for health care provided to an individual, whether such information is in paper, electronic or verbal form;
- Medical information concerning the patient's history of illness, mental, or physical condition, diagnosis, treatment, prognosis, test results, verbal conversations, research records and financial information, etc., as well as the patient's family members' health and financial information.
- Insurance, financial and billing information regarding the patient or patient's representatives;
- Information acquired about a patient or patient's family as a result of their seeking health care or services from HRRMC;
- Visual observation of patients receiving medical care or accessing services from HRRMC; and
- Verbal information provided by or about a patient.

**Confidential Employee and Business Information includes but is not limited to the following:**

- An employee's home telephone number and address; spouse's or other relatives' names; Social Security Numbers or income tax withholding records;
- Information related to evaluation of employee performance, disciplinary action, or personnel file information;
- Peer review, risk management and quality improvement activities and information protected from disclosure by law or under the attorney-client privilege;
- Other such information obtained from HRRMC records which, if disclosed, could constitute an unauthorized invasion of privacy; and
- Disclosure of confidential business information, such as trade secrets or other proprietary information, that would cause harm to HRRMC.

**I agree to maintain and protect the privacy, security and confidentiality of the above forms of information. I will use and disclose confidential information only (i) as necessary for me to perform my legitimate duties as defined by my employment, contractual or other affiliation relationship with HRRMC, and (ii) when authorized by law and HRRMC policy. I specifically understand and agree to the following:**

1. **EDUCATION AND TRAINING:** I acknowledge that I receive periodic education and training from HRRMC regarding laws, regulations and HRRMC policies and procedures governing access, use and disclosure of confidential information, and I agree to comply with such legal, regulatory and policy requirements at all times.
2. **LOCATION OF POLICIES:** I have been informed that HRRMC's policies and procedures pertaining to confidential information can be found via the link on the HRRMC intranet.
3. **SECRECY OF UNIQUE IDENTIFYERS, USERNAMES AND PASSWORDS:**
   a. I will not disclose my usernames and passwords with anyone.
   b. I will be responsible for misuses or wrongful disclosures of confidential information resulting from my unauthorized sharing of my access codes with another person and/or for failure to appropriately safeguard my access to confidential information.
   c. I will log off HRRMC computer systems after use and when I am away from my workstation, auto time-out is adequate.
   d. I will not log on to a system or access confidential information to allow another person access to that information or to use that system, except for IT troubleshooting or support.
   e. I will report any suspicion or knowledge that my access code, authorization, or any confidential information has been misused or disclosed without proper authorization.
4. **SAFEGUARDING CONFIDENTIAL INFORMATION:**
   a. I will access, use and disclose confidential information only as needed by me to perform my legitimate duties as defined by my role and job description.
   b. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other confidential information generated in connection with individual patient care, risk management and/or peer review activities.
   c. I will not access, use or redisclose any confidential information which I have no legitimate need to know.
   d. I will not in any way photograph, store, transmit, disclose, copy, release, alter, revise, or destroy any confidential information except as authorized by law and HRRMC policy and within the scope of my HRRMC role and job description.

HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

P.O. Box 429
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719.530.2200

e. I will not misuse or carelessly handle confidential information. I will not download or transfer computer files containing confidential information to any non-HRRMC computer, data storage device, portable device, telephone, or other device capable of storing digitized data.
f. I understand that it is my responsibility to ensure that confidential information in my possession is maintained in a physically secure environment, and is transported in a secure manner.
g. I will only print documents containing confidential information in a physically secure environment, will not allow other persons' access to printed confidential information, will store all printed confidential information in a physically secure environment, and will destroy all printed confidential information when my legitimate need for that information ends, in a manner that protects the confidentiality of the information from unauthorized use and disclosure.
h. I will not access, view, copy, photograph, record or share with others, verbally or in other form, any confidential information of a family member, coworker, friend, neighbor, public figure or others without proper authorization.

5. **ACCESS TO MY OWN HEALTH AND BILLING INFORMATION:** Accessing my own health and billing information via paper or the electronic health record and other systems without proper authorization from HRRMC is prohibited. I understand that if I want to view or receive copies of my medical record I must go to the Medical Records Department and complete an "Authorization for Disclosure of Health Information" form. The department representative will retrieve the records for me. I am aware that I have the option to access certain of my health information via the online Patient Portal. I understand that if I want access to my billing information I must contact the Patient Financial Services Department and follow the established protocol for obtaining such information.
6. **SECURITY OF CONFIDENTIAL INFORMATION:** I will keep all confidential information secure from being seen, accessed or shared with others who are not authorized to have the information.
7. **EMAIL, INTERNET, CELL PHONE, SECURE TEXTING, AND CAMERA USE:** My usage of the HRRMC email system, internet, cell phone, secure texting, and camera use will comply with the policies of HRRMC, and with all applicable laws and regulations, including but not limited to HIPAA or copyright law. Use of any social media venues such as Facebook, Myspace, Instagram, Twitter, Linked-In, and cell phones, pictures/video (with the exception of the HRRMC approved secure texting application), audio, or public blogs are prohibited for posting or communicating confidential HRRMC information.
8. **OWNERSHIP OF INFORMATION AND RECORDS:** I acknowledge that any information or records I create or receive in my capacity as a member of the HRRMC Medical Staff, or in the course of providing care and services to HRRMC patients, or in the course of fulfilling my professional responsibilities as a member of the HRRMC Medical Staff, including but not limited to any HRRMC patients' medical records, HRRMC peer review records, and any HRRMC proprietary or other business information, are and shall remain the property of HRRMC; provided, however, this provision shall not apply to any information or records I create or receive in my own private, independent medical practice and that are unrelated to my roles and responsibilities as a member of the HRRMC Medical Staff or to my relationship with HRRMC.
8. **REPORT OF KNOWN AND SUSPECT PRIVACY VIOLATIONS:** I will report known and suspected violations of these requirements to the HRRMC Compliance Hotline and to the Privacy Officer.
9. **AUDITING:** I understand that HRRMC performs routine audits and reviews patient records and other information systems in order to identify inappropriate and unauthorized access, use and disclosure of confidential information.
10. **DISCIPLINE AND LIABILITY:** I understand that in the event of a breach or threatened breach of this Confidentiality Agreement and/or HRRMC policies, I may be subject to disciplinary and corrective action up to and including permanent suspension from the Medical Staff of HRRMC, in addition to legal and/or financial liability.

**Acknowledgement to be reviewed and signed upon initial credentialing and at every re-credentialing cycle thereafter:**

*I certify by my signature that I have read, understand and agree to the terms and conditions of this Confidentiality Agreement.*
*I understand that my obligation to safeguard patient confidentiality and other confidential HRRMC information continues after I am no longer a member of the HRRMC Medical Staff.*

Medical Staff Member Printed Name Signature Date Signed

**Attestation by Applicant and/or Privileged Provider**

*My signature confirms that I have reviewed and agree to follow this Code of Conduct. I commit to the HRRMC mission, vision and values, as I interact with patients and the patient care team at HRRMC.*

*I have received a copy of Heart of the Rockies Regional Medical Center's Medical Staff Bylaws, Rules and Regulations, and associated Medical Staff Policies & Procedures and agree to abide by them.*

*Signature:* _____

*Please print name:* _____

*Date:* _____


| | |
|---|---|
| **Issued:** | *04/2003* |
| **Approved:** | *10/2014* |
| **Last Revised:** | *08/2013* |
| **Expiration:** | *10/2015* |
| **Owner:** | *Roxanne Clark: MR Manager* |
| **Policy Area:** | *HIPAA Privacy Policies* |
| **References:** | |

# Safeguarding Protected Health Information, HIP1109



## Policy:

It is the policy of Heart of the Rockies Regional Medical Center ("HRRMC") to safeguard ***Protected Health Information*** ("***PHI***") from any intentional, unintentional or incidental ***Use*** or ***Disclosure*** in violation of the HIPAA Privacy Standards by employing administrative, technical, and physical safeguards, as provided by this policy and procedure.

## Purpose:

To provide guidelines for safeguarding ***PHI***. This requirement applies to all types of ***PHI*** in any form, i.e., oral, paper, or electronic. For additional requirements specific to ***PHI*** in electronic form, refer to HRRMC's HIPAA Security Standards policies.

## Responsibility:

All ***Workforce Members***

## Key Definitions:

Bold and Italicized terms used in this procedure are defined in the HIPAA Glossary.

## Procedure:

A. Administrative Safeguards

1. HRRMC will verify the identity and authority of an unknown person requesting ***PHI***, as provided in the "Verification of Identity" policy.
2. HRRMC will ensure its compliance with the HIPAA Privacy Standards by:
    a. Providing a process for filing complaints concerning the Hospital's privacy practices, as described in the "Customer Complaint Resolution" policy;
    b. Providing privacy training to its ***Workforce Members***; and
    c. Imposing sanctions upon the ***Workforce Members*** who violate the HIPAA Privacy Standards or HRRMC's policies and procedures, as established in the "Workforce Sanctions" policy.

3. HRRMC will take any other administrative safeguards to protect ***PHI***, as appropriate. For example**:**
    a. Requiring ***Workforce Members*** to wear some form of visible identification;
    b. Limiting access to ***PHI*** to ***Workforce Members*** who need it to perform their job functions, as provided in the "Minimum Necessary" policy; and
    c. Reporting actual or suspected breach of security.

B. Technical Safeguards

1. HRRMC will take any appropriate technical safeguards to protect ***PHI*** maintained in electronic form and minimize incidental ***Use*** and ***Disclosure*** as provided in the "Security of Technology" policy.

C. Physical Safeguards

1. HRRMC will take any appropriate physical safeguards to protect ***PHI*** by:
    a. Securing areas where ***PHI*** is stored, in order to limit access, by putting a lock on doors, cabinets or drawers or by using an entry control system;
    b. Shredding documents containing ***PHI*** before disposing of them;
    c. Using a sign-in and escort procedure to account for vendors as appropriate; and
    d. Not leaving documents containing ***PHI*** unattended and unsecured.
2. HRRMC will minimize incidental ***Uses*** and ***Disclosures*** by appropriate physical safeguards to protect ***PHI*** by:
    a. Limiting discussion of a patient's ***PHI*** in public areas;
    b. Placing whiteboards, computer monitor printers, fax machines and any other equipment that displays ***PHI*** in a way that passers-by cannot see it; and
    c. Limiting the type of ***PHI*** on a sign-in sheet or when paging a patient to least amount necessary to accomplish the purpose.



D. Documentation Retention

1. All documents required under this policy shall be maintained on site, in accordance with HRRMC's Document Retention Policy.

E. Contact for Questions

1. If a ***Workforce Member*** has any questions or is uncertain about the correct procedures for Safeguarding ***Protected Health Information*** will contact Privacy Officer.

# Reference:

A. "Customer Complaint Resolution" policy #HIP1103

B. "Minimum Necessary" policy #HIP1105

C. "Security of Technology" policy #HIP1110

D. "Workforce Sanctions" policy #HIP1114

E. "Retention and Destruction of Records" policy #ADM1001

## Associated CMS Standards:

45 C.F.R. § 164.530(c)

**Current Status:** *Active* **PolicyStat ID:** *1243972*


| | |
|---|---|
| **Issued:** | *04/2003* |
| **Approved:** | *12/2014* |
| **Last Revised:** | *06/2011* |
| **Expiration:** | *12/2015* |
| **Owner:** | *Roxanne Clark: MR Manager* |
| **Policy Area:** | *HIPAA Privacy Policies* |
| **References:** | |

# Minimum Necessary, HIP1105

## Policy:

Heart of the Rockies Regional Medical Center ("HRRMC") will make reasonable efforts to limit the amount of ***Protected Health Information*** **("*PHI* ")** that is ***Used*****,** ***Disclosed*****,** or requested, to only the minimum amount of *PHI* that is necessary to accomplish the intended purpose of the ***Use*****,** ***Disclosure*****,** or request.

## Purpose:

To comply with the HIPAA mandates. This policy will define the least amount of ***PHI*** that can be ***Used*****,** ***Disclosed*****,** or requested.



## Responsibility:

All ***Workforce Members***

## Key definitions:

Bold and Italicized terms used in this procedure are defined in the HIPAA Glossary.

## Procedure:

A. ***Minimum Necessary*** Standard

1. When using or disclosing ***PHI*** or requesting ***PHI*** from another Covered Entity, HRRMC will make reasonable efforts to limit the ***PHI*** to the ***Minimum Necessary***.
2. The ***Minimum Necessary*** requirements contained in this policy **DO NOT** apply to the following:
   a. ***Disclosures*** to or requests by a healthcare provider for treatment purposes, payment or operations;
   b. ***Disclosures*** made to the individual who is the subject of the ***PHI***;
   c. ***Disclosures*** made under an ***Authorization*** requested by the individual;
   d. ***Disclosures*** made to the Secretary of the Department of Health and Human Services;
   e. ***Uses*** and ***Disclosures*** that are required by law;
   f. ***Uses*** and ***Disclosures*** required by compliance with HIPAA.

B. ***Minimum Necessary*** for Internal ***Uses***

1. The Medical Records Department is responsible for identifying those persons or categories of persons at HRRMC who need access to ***PHI*** to carry out their duties.
2. The Medical Records Department will identify any conditions that will apply to each person's or department access to ***PHI***. (See Attachment A)
3. The Medical Records Department is responsible for implementing procedures set forth that classifies who is entitled access to ***PHI***, the types or categories of ***PHI*** to which such persons or classes can access and any conditions to such access, and documenting these procedures. (See Attachment A) The Medical Records Department is responsible for overseeing and making reasonable efforts to ensure that such procedures are followed and/or are revised as necessary.
4. In no event will the ***Minimum Necessary*** rules and procedures be interpreted or implemented in a manner that impedes or obstructs the delivery of quality patient care.
5. The Medical Records Department will review the procedures it creates on an as-needed basis, but not less than quarterly, to identify any changes that need to be made to the access permitted by such procedures. Any requests from the healthcare providers, nursing, medical and support staff for changes in access to ***PHI*** will be directed to the Medical Records Department/Privacy Officer.

C. Routine and Recurring ***Disclosures*** to Third Parties

1. For ***Disclosures*** that HRRMC makes on a routine, recurring basis, HRRMC must limit the ***PHI Disclosed*** to the ***Minimum Necessary*** to achieve the purpose of the ***Disclosure***.
2. The Medical Records Department is responsible for ensuring that all departments in HRRMC identify ***Disclosures*** of ***PHI*** that they make on a routine, recurring basis.
3. The Medical Records Department is responsible for assisting each department in creating standard protocols to ensure that routine ***Disclosures*** include only the ***Minimum Necessary PHI***. Each protocol developed must address the following.
    a. The protocol must set forth the type of ***PHI*** that can be ***Disclosed***.
    b. The protocol must identify the types or categories of persons to whom the ***PHI*** identified in the protocol can be ***Disclosed***.
    c. The protocol must identify any applicable conditions to providing the ***Disclosure***.
    d. The Medical Records Department is responsible for ensuring that protocols are created and implemented as required under this section.
    e. The Medical Records Department in conjunction with the Privacy Officer is responsible for making the final determination as to whether a ***Disclosure*** can be categorized as "routine and recurring".
    f. If a ***Disclosure*** cannot be categorized as "routine and recurring" then the requirements set for in Section D will apply.

D. Non-Routine ***Disclosures*** to Third Parties

1. For ***Disclosures*** that do not fall within Section C, HRRMC will take steps to limit them to the ***Minimum Necessary***. All ***Disclosures*** that are not routine and recurring and that do not otherwise meet an exception set forth in this policy must be reviewed on an individual basis in accordance with this Section.
2. The Medical Records Department, together with appropriate health care professions, will be

responsible for developing criteria to be applied to analyze non-routine ***Disclosures*** to determine the ***Minimum Necessary PHI*** that can appropriately be ***Disclosed***.

3. All non-routine ***Disclosures*** must be forwarded to the Medical Records Department for review and approval prior to making the ***Disclosure***. The Medical Records Department will be responsible for reviewing each non-routine ***Disclosure*** and determining the ***Minimum Necessary PHI*** that can be included in the ***Disclosure***.
4. Requests for ***Disclosures*** by the following entities will be deemed to be the ***Minimum Necessary*** for the stated purpose and do not require individual review by the Department:
    a. ***Disclosures*** to a public official in accordance with applicable law, if the public official represents that the information requested is the ***Minimum Necessary***;
    b. The information is requested by another health care provider, health plan, or health care clearinghouse;
    c. The information is requested by a healthcare provider e.g. nursing, medical and clinical support staff of HRRMC or by a Business Associate of HRRMC for the purpose of providing that the information requested is the ***Minimum Necessary*** for the stated purpose(s); or
    d. In the event a healthcare provider, nursing, medical or clinical support staff believe that a request for a ***Disclosure*** involving ***PHI*** from a person or entity listed in Section 4c above is not the ***Minimum Necessary***, such workforce members must raise his or her concerns with the Medical Records Department. The Medical Records Department is responsible for evaluating such requests for ***Disclosure*** and determining whether it is reasonable for HRRMC to rely on such a request. The Medical Records Department will consult with the Privacy Officer in making such determinations.
        1. The Medical Records Department or the Privacy Officer will contact the person or entity making the ***Disclosure*** request to discuss the concerns raised by the request.
        2. The Medical Records Department is responsible for documenting all decisions regarding ***Disclosures*** under this Section.

E. Routine Request from HRRMC for Information to other Covered Entities

1. When requesting ***PHI*** from other Covered Entities, HRRMC must limit any request for ***PHI*** to the ***Minimum Necessary*** to accomplish the purpose for which the request is made.
2. The Medical Records Department is responsible for ensuring that all Departments and functions within HRRMC identify requests for ***PHI*** that they make on a routine, recurring basis.
3. The Medical Records Department is responsible for assisting each applicable department or function in creating standard protocols to ensure that routine requests for ***Disclosures*** of ***PHI*** are limited to the ***Minimum Necessary***. Each protocol developed under this Section must address the following:
    a. The protocol must set forth the type of ***PHI*** that can be requested.
    b. The protocol must identify the types or categories of persons from whom the ***PHI*** identified in the protocol can be requested.
    c. The protocol must identify any applicable conditions to making the request.
    d. The Medical Records Department is responsible for ensuring that protocols for routine requests for ***PHI*** are created and implemented as required under this Section.
    e. The Medical Records Department, in consultation with the Privacy Officer, is responsible for

making the final determination as to whether a request for ***PHI*** can be categorized as "routine and recurring".

f. If a request for ***PHI*** cannot be categorized as "routine and recurring", then the requirements set for in Section F will apply.

F. Non-Routine Requests for Information from HRRMC to other Covered Entities

1. For requests that do not fall within Section E, HRRMC will take steps to limit them to the ***Minimum Necessary***. All requests that are not routine and recurring must be reviewed on an individual basis in accordance with this Section.
2. The Medical Records Department, together with appropriate health care professionals, will be responsible for developing criteria to be applied to analyze non-routine requests to determine the ***Minimum Necessary PHI*** that can appropriately be requested.
3. All non-routine requests must be forwarded to the Medical Records Department for review and approval prior to making the request. The Medical Records Department will be responsible for reviewing each non-routine request and determining the ***Minimum Necessary PHI*** that can be requested.

G. Rules for the Entire Medical Record

1. HRRMC will not ***Use***, ***Disclose***, or request an entire medical record, except when the Medical Records Department, in consultation with a health care professional in the exercise of his or her professional judgment, determines that the entire medical record is specifically justified as the ***Minimum Necessary*** to accomplish the purpose of the ***Use***, ***Disclosure***, or request.

H. Documentation Retention

1. All documents created or completed by this policy will be maintained according to HRRMC's document retention policy.

I. Contact for Questions

1. If a Workforce Member has any questions or is uncertain about the correct procedure on the ***Use*** or ***Disclosure*** of, or request for only the ***Minimum Necessary PHI***, such Workforce Member will contact the Privacy Officer or the Medical Records Department.



# Reference

A. "Retention and Destruction of Healthcare Business Records" policy #ADM1001

## Associated CMS Standards:

164.502(b) & 164.514(d)

## Attachments:

ATTACHMENT A.docx

## Approval Signatures

| Approver | Date |
|---|---|
| Roxanne Clark: MR Manager | 12/2014 |
| Roxanne Clark: MR Manager | 12/2014 |

HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

**ATTACHMENT A**

| Job Functions | Categories of PHI Needed | Conditions |
|---|---|---|
| Admissions Personnel | Physician orders to generate the face sheet, past, present and future payment information | Insurance and physician information. |
| Ambulance Personnel (EMS) ("***Disclosure***") | Routine and Recurring Disclosures | Case reviews for PI education. De-identify as necessary to maintain educational benefits without disclosing unnecessary PHI. |
| Ancillary Staff (Radiology, Pathology, Laboratory, Rehab Services, and Cardiopulmonary) | Reports specific to the department. Radiology - imaging films, face sheet, orders, radiological reports. Cardiopulmonary – entire chart Lab – orders, face sheet | Clarification, verification, and presence of reports. Use of patient identifiers, especially patient name, should be minimized. Avoid/limit use of sensitive diagnoses. |
| Board of Directors | None. | None. |
| Central Options for Long Term Care (Medicaid Case Management) | Entire chart | Only for the patient for whom they are responsible. Exception – supervisor required to review for completeness and meeting state requirements. |
| CEO | Entire medical record, past, present and future payment information. | Appropriate supervision, problem solving and customer service issues. |
| Chaplain | Directory information only | Indicated at the time of admission by the patient. |
| CNA | Face sheet and graphics. | Data input only. Use of patient identifiers, especially patient name, should be minimized. Avoid/limit use of sensitive diagnoses. |
| Coder | Entire medical record | To properly code a record for billing process. Use of patient identifiers, especially patient name, should be minimized. Avoid/limit use of sensitive diagnosis. |
| Dietary Manager | Physician orders, progress notes, H&P, graphics | To do a nutritional assessment |
| Dietary Staff | Physicians Orders Only | To prepare appropriate meals |
| Discharge Planning | Entire Chart | Necessary for making appropriate arrangements based on patient and family needs and requirements |
| Environmental Services | None | None |
| File Clerk | Face sheet, physician orders, loose papers, i.e. reports. | For proper filing and storage of record. Use of patient identifiers, especially patient name, should be minimized. Avoid/limit use of sensitive diagnoses. |
| Foundation Director and Staff | Patient demographic information to include: name, address, telephone number(s), age (including whether | For purposes of sending patient an authorization to allow or prohibit future contact for solicitation |

| | | |
|---|---|---|
| | deceased), gender, and insurance status. | purposes. Specifically no date of service, type of service or diagnosis information may be accessed. |
| Health Information Management Personnel | Entire medical record. | Assembly of record, coding, analysis, routing, storage, QI/QA. Use of patient identifiers especially name should be minimized. Avoid/limit use of sensitive diagnoses. |
| Hospital & Physician Office Billing/Collections Personnel | H&P, D/S, face sheet, physician orders, progress notes, past, present and future payment information, principal diagnosis | To support claim information. |
| Hospital Patient Financial Services Manager | H&P, D/S, face sheet, physician orders, progress notes, past, present and future payment information | To support claim information. |
| Hospital Volunteers | Directory information only | Indicated at the time of admission by the patient. |
| Infection Control Personnel | Entire medical record. | For reporting information regarding infection and employee health. |
| Interns, students (RN, MD, etc.) | Entire chart | Only for those patients for whom they are responsible. |
| IS Manager and Staff | Diagnostic images and results stored/transferred electronically, hard copy and electronically stored PHI up to an including entire medical record | To provide technical support and problem resolution to users of all applications of the HIS in/through which PHI is entered/stored/transferred and to compile/provide PHI for patient satisfaction surveying. Use of patient identifiers, especially patient name, should be minimized. Avoid/limit use of sensitive diagnoses. |
| Massage Therapist | Entire Medical Record | Only for patients for whom responsible; only during on-duty hours |
| Materials Management | None | |
| Medical Assistant | Entire chart | Only for patients for whom responsible; Only during on-duty hours |
| Medical Director (specify each function relevant to ***PHI***) | Entire medical record | While entire medical record must be reviewed to perform QA/QI appropriately, information reported should avoid use of unnecessary identifiers; especially name, and avoid/limit use of sensitive diagnoses unless necessary for |

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| | | appropriate QA/QI function or follow up. |
| Nurse Performing QA/QI | Entire Medical Record | While entire medical record must be reviewed to perform QA/QI appropriately, information reported in QA/QI from will avoid use of unnecessary identifiers; especially name, and avoid/limit use of sensitive diagnoses unless necessary for appropriate QA/QI function or follow-up |
| Nurse Performing Treatment ("***Use and disclosure***") | Entire Medical Record | Only for patients for whom responsible; Only during on-duty hours |
| Nurse Supervisor | Entire Medical Record | While entire medical record access is necessary for appropriate supervision and problem-solving assistance, use of patient identifiers in reports (verbal or written) will be minimized, especially name. Avoid/limit use of sensitive diagnoses unless necessary for supervisor functions |
| Personal Care Provider | Work order only | For proper completion of patient care. |
| Pharmacy Personnel | Face sheet, physician orders, medication sheets, progress notes, lab reports, and graphics. Pharmacist – entire medical record. | Patient education and profiling of medications/drug therapies and regimes. |
| | | |
| Physician Peer Reviewer | Entire Medical Record or Charts meeting review criteria | While entire chart is necessary for thorough review, limit or eliminate, if possible, patient identifiers in reports and conversations, by assigning a different identification for purposes of outside peer review. |
| Physician/PA-C/FNP/CRNA Performing Treatment or Referring Patient Inside Hospital ("***Use***") | Entire Medical Record | Only for patients for whom responsible (as attending, consulting) |
| Physician Referring Patient Outside Hospital for Treatment ("***Disclosure***") | ***Minimum Necessary*** Rules Not Applicable | N/A |
| Physician/CRNA Receiving Referral of Patient Inside Hospital ("***Use***") | Entire Medical Record | Only for patient being referred |
| PR/Marketing Manager | Aggregate and directory information only. | |
| Public Officials (Law | Entire medical record | As pertaining to specific incident |

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| Enforcement, Colorado State Health Department, Coroner) | | being reviewed/investigated |
| Risk Manager | Entire medical record | Safety issues in reference to liability claims. |
| Ski Patrol (Emergency Medical Response) ("Disclosure") | Routine and Recurring Disclosures | Case reviews for PI education. De-identify as necessary to maintain educational benefits without disclosing unnecessary PHI. |
| Transcriptionist | Entire medical record. | For clarification of dictated information. Use of patient identifiers, especially patient name, should be minimized. Avoid/limit use of sensitive diagnoses. |
| **Job Functions** | **Categories of PHI Needed** | **Conditions** |
| Utilization Review/QA/QI Personnel | Entire medical record. | Insurance qualifications and requirements. QA/QI for Medicare issues. Use of patient identifiers, especially patient name, should be minimized. Avoid/limit use of sensitive diagnoses. |
| Vice President of Ancillary Services. | Physician orders, facesheets, reports, radiology film, film jackets, physical therapy reports, cardiopulmonary reports, lab reports | Clarification, verification, and presence of reports. Use of patient identifiers, especially patient name, should be minimized. Avoid/limit use of sensitive diagnoses. |
| Vice President of Financial Services | H&P, D/S, facesheet, physician orders, progress notes, past, present and future payment information | To support claim information. |
| Vice President of Human Resources | Entire Emergency Dept. record of HRRMC employee only, Health Plan Information | To clarify and verify information on Workers' Compensation claims. To manage employee benefit packages. |
| Vice President of Nursing | Entire Medical Record | See Nurse Performing QA/QI, Nurse Supervisor, Risk Manager, and CEO |
| Ward Clerk/Unit Secretary | Entire medical record | While entire medical record access is necessary for job function, use of patient identifiers should be minimized, especially name, while on shift. Avoid/limit use of sensitive diagnoses. |

**MANUAL: Medical Staff AUTHOR: Medical Executive Committee of the Medical Staff, David M. Arnett, M.D., Chief of Staff, and Carolyn Webb, Medical Staff Coordinator**

**SUBJECT: CODE OF CONDUCT AND PROFESSIONAL EXPECTATIONS – MEDICAL STAFF AND ALLIED HEALTH PROFESSIONALS**

## I. Policy

Members of the Medical Staff and Allied Health Professionals who are authorized to practice at our facility under the auspices of the Medical Staff ("practitioners") are expected to conduct themselves in a manner that upholds the mission, vision and core values of Salida Hospital District d/b/a Heart of the Rockies Regional Medical Center ("HRRMC").

### *Mission Statement*

HRRMC exists to enhance the health of our community through the delivery of personalized and exceptional care.

### *Vision Statement*

The vision of HRRMC is to be the provider of choice for our region as a world-class rural healthcare organization.

### *Core Values*

HRRMC has adopted the following values to guide the everyday behavior of each and every employee or member of the medical staff or allied health professional staff:

- Teamwork
- Recognition
- Attitude
- Customer Service
- Safety
- Talent
- Accountability
- Respect

## II. Expectations

Practitioners are expected to:

A. Quality Care and Technical Skills

1. Provide appropriate patient care, including the selection of efficient and appropriate approaches to diagnosing and treating patients using available evidence-based guidelines.
2. Provide for patient comfort, including prompt and effective management of acute and chronic pain according to accepted standards.

3. Work to achieve patient outcomes that consistently meet or exceed accepted HRRMC medical staff standards as defined by comparative data, medical literature and results of peer review activities.

B. Quality Services

1. Ensure timely and continuous care of patients, 24 hour per day, seven days per week, including clear identification of the person(s) covering for the practitioner and by responding appropriately and timely when contacted with questions regarding patient care.
2. Evaluate each patient as often as necessary but at least every twenty-four hours during an acute hospital stay and no less than every seven (7) days for each swing-bed stay.
3. Participate in emergency room call coverage as determined by the Medical Executive Committee (MEC).
4. When requesting consultations on inpatients, communicate directly with the consultant and clearly state the reason for the consultation.
5. When asked to consult on the care of an inpatient, complete the consultation in a timely manner or promptly notify the person requesting the consultation if unable to provide the consultation.
6. Respond promptly to nursing requests for patient care.
7. Participate in HRRMC's efforts to continually improve patient satisfaction.
8. Communicate effectively with other physicians and caregivers, patients, their families and patient's surrogate decision makers.

C. Patient Safety/Patient Rights

1. Participate in HRRMC's efforts to reduce medical errors and support a culture of safety at HRRMC.
2. Follow nationally recognized recommendations regarding infection control procedures and precautions.
3. Make entries in medical records consistent with the medical staff bylaws, rules and regulations including but not limited to legibility, use of appropriate abbreviations and timely completion of reports and notes.
4. Respect patient rights including discussing unanticipated adverse outcomes with the patient and/or the patient's surrogate decision maker.
5. Respect patients' privacy by not discussing a patient's care in public settings and otherwise following HRRMC's HIPAA policies.
6. Personally identify yourself and your professional title when seeing or attending patients, which identification should include wearing a personal identification badge and verbally introducing yourself to all patients, using your professional title as part of that introduction (ie: Hello, I am Dr. John Smith).

7. When appropriate, discuss end-of-life issues, including advance directives, with patients, their families and surrogate decision makers, if any, and honor patient decisions.

D. Resource Utilization

1. Strive to provide quality, cost effective patient care consistent with other comparative medical centers and current professional standards.
2. Follow guidelines for hospital admissions, level of care transfers, and discharges to outpatient management.
3. Provide accurate and timely discharge orders and instructions in collaboration with other caregivers.

E. Peer and Health Care Team Relationships

1. Demonstrate collaboration with the entire health care team based on mutual desire for the best possible care of the patient.
2. Communicate both verbally and in writing in a clear, concise, non-judgmental and respectful manner.
3. Do not engage in behavior that is disruptive, discriminatory, sexually harassing, disrespectful, derogatory or inflammatory.
4. Address disagreements in a constructive, respectful manner away from patients and others not involved in the disagreement.

F. Citizenship

1. Review the practitioner's individual quality data provided by HRRMC and utilize this data to continually improve patient care practices.
2. In the spirit of continuous improvement, respond when contacted regarding concerns about patient care.
3. Respond in a timely manner to issues on which medical staff input is requested.
4. Make constructive contributions to the medical staff by participating actively in medical staff functions and serving on committees and workgroups when requested.
5. Comply with policies and procedures of the medical staff and Heart of the Rockies Regional Medical Center, Medicare Conditions of Participation for Hospitals, and the regulations of the Colorado Department of Public Health and Environment.
6. Help identify issues affecting the physical and/or mental health of fellow practitioners and cooperate with programs providing assistance.

## III. HRRMC'S Commitments to the Medical Staff

HRRMC makes the following commitments to practitioners:

A. We will continually strive for the highest quality of patient care.
B. We will involve physicians in the strategic planning for patient clinical needs.
C. We will conduct all peer review consistent with applicable requirements, the Medical Staff Bylaws, and the Medical Staff Policies & Procedures.
D. We will provide opportunities for practitioners to share concerns regarding quality and safety with HRRMC administration and medical staff leaders.
E. We will recruit and train high caliber healthcare workers.
F. We will train HRRMC staff to communicate effectively and to work collaboratively.
G. We will fairly evaluate behavior and quality concerns reported regarding practitioners or HRRMC employees.
H. We will seek input from physicians in the development of patient care policies.

## IV. Conduct within the Medical Center

All members of the health care team, including practitioners, are expected to treat others with respect, courtesy and dignity and conduct themselves in a professional and cooperative manner. Safety and quality patient care depend on teamwork, communication, and collaboration. All members of the health care team are expected to conform to the expectations described in Section II of this policy and to refrain from disruptive behavior. Disruptive behavior undermines safety, can foster medical errors and preventable adverse outcomes and will not be tolerated. The protection of patients, HRRMC employees, practitioners and visitors, and the orderly operation of HRRMC are paramount.

"Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, subject to treatment as "disruptive behavior."

"Disruptive behavior" may include, but is not limited to:

A. Threatening, intimidating, or abusive language (e.g., belittling, berating, and/or threatening another individual) directed towards any HRRMC employee, any patient, any family member of a patient, or any other practitioner;
B. Profanity or other offensive language which may not necessarily be directed towards any one specific individual;
C. Jokes or derogatory comments related to race, ethnicity, gender, sexuality, disability, national origin, or religion;

D. Degrading or demeaning comments including derogatory comments about the quality of care provided by other practitioners, HRRMC employees, or HRRMC;
E. Inappropriate entries in a medical record, such as comments regarding the quality of care provided by other practitioners, HRRMC employees or HRRMC;
F. Inappropriately accessing medical records of any patient or patients for whom the practitioner is not providing care;
G. Noncompliance, whether passive or active, with medical center and medical staff policies;
H. Disregard of patient confidentiality or patient safety;
I. Behavior that is not appropriate to the care of patients or interferes with employee relationships in the setting of HRRMC including, but not limited to, inappropriate touching, sexual or otherwise, physical harassment or abuse, sexual harassment or abuse, emotional harassment, throwing instruments or objects, or theft, damage or destruction of HRRMC property; or
J. Accessing inappropriate Internet sites, or displaying derogatory or suggestive pictures or objects.

## V. Process to resolve complaints regarding disruptive behavior

HRRMC encourages evaluation and management of conflicts, disagreements, and other differences of opinion through appropriate channels. HRRMC also encourages practitioners to report disruptive behavior to HRRMC and medical staff leadership for resolution. There will be no reprisal for reporting concerns in accordance with this policy or in accordance with regulations of CMS' Conditions of Participation or the Colorado Department of Public Health and Environment.

A. **First Steps.** If an individual is subjected to or observes disruptive behavior by a practitioner as herein defined, it is appropriate for the individual to ask (on their own behalf or on behalf of the person subjected to such behavior) that the behavior stop. The parties involved should speak calmly, privately, and resolve the incident in a positive and constructive manner on an informal basis as soon as possible. This collegial step should generally be taken first in an attempt to stop disruptive behavior. Some behavior may be so egregious, however, as to warrant an immediate referral to the Chief Executive Officer, another member of the senior leadership team of the Medical Center (Nursing Supervisor after hours), or Medical Staff leadership Such referral may be made at any time.

B. **Disruptive Behavior by a HRRMC Employee.** Disruptive behavior by a HRRMC employee directed to or witnessed by a Medical Staff member that is egregious, repeated, has the potential to jeopardize patient care or hospital

operations, or is not resolved through collegial intervention as outlined above should be reported to any member of the HRRMC Administrative staff. Disruptive behavior by HRRMC employees will be dealt with in accordance with the HRRMC's employment policies. Further, HRRMC employees who are also privileged to provide care under Medical Staff mechanisms are subject to further action under Section C, et seq, below.

C. **Disruptive Behavior by a Practitioner who is not a HRRMC Employee or is an employee who has also been privileged to provide care under Medical Staff credentialing mechanisms.** A concern with disruptive behavior by a practitioner who is not a HRRMC employee or an employee who has also been privileged to provide care under Medical Staff credentialing mechanisms which is egregious, repeated, has the potential to jeopardize patient care or hospital operations, or is not resolved through collegial intervention as outlined in Section A, above, should be handled through the following process. If the concern is with the behavior of an Allied Health Professional Staff member as those individuals are defined in the Medical Staff's Bylaws, that individual's sponsoring physician will be expected to participate in the process at Level 2 or above.

1. The attached flow chart outlines the process to follow when HRRMC employees, patients or others report behavior concerns regarding a practitioner's behavior. Note that egregious breaches in conduct or patient safety must be forwarded ***immediately*** to the Chief of Staff and/or to the Chief Executive Officer or VP-Nursing/Quality & Risk Operations to assure safety of patients, staff, and other HRRMC practitioners. (During non-business hours and/or in the event of an urgent/emergent situation, the Nursing Supervisor should be contacted and then s/he will then ***immediately*** contact the administrator on-call. A written report of the behavior should then be completed as soon as possible and processed in accordance with this policy.)

2. Any person, whether an employee or other individual, reporting disruptive behavior must complete a written report of the behavior on the attached form, including the name of the person reporting the matter. Once the report of disruptive behavior is completed, it should be submitted to the Nursing Supervisor, the appropriate department manager, and/or the appropriate Vice President in senior leadership at HRRMC and ultimately be forwarded to the appropriate Vice President for further investigation.

3. Upon receipt of the report of disruptive behavior, the behavior will be investigated by the senior member of the Administrative Team who receives

the report. A preliminary classification shall be assigned to the report based on the findings of the investigation using the following guidelines:

a) **Level 1** – an unsubstantiated claim on which no further action is necessary. The Practitioner and the individual initiating the report shall be advised that it has been determined to be unsubstantiated and no record of an unsubstantiated claim shall be maintained.

b) **Level 2** – A substantiated claim of disruptive conduct of a minor nature (i.e.: problem with communication between the individuals involved which can be resolved through simple behavior modification and better communication techniques, etc.) the recurrence of which shall be trended.

The first incident of mild (Level 2) disruptive behavior shall be investigated and, if substantiated by the Vice President, the Chief Executive Officer and the Chief of Staff or designee shall notify the practitioner and discuss the incident. A commitment from the practitioner not to repeat the behavior shall be required and a copy of the report will become a part of practitioner's Performance Improvement file for further reference. If no further reports are received within twenty-four (24) months, the first report of mild disruptive behavior shall be purged from the practitioner's Performance Improvement file

If a second incident of mild disruptive behavior occurs within twenty-four (24) months, the second incident shall be investigated and, if substantiated by the Vice President, the Chief Executive Officer and the Chief of Staff or designee shall notify the practitioner and meet with the practitioner with the intent to develop a plan to prevent future incidents and escalation of the severity of the leveling of such incidents. The practitioner should be advised that a trend of three (3) or more reports of mild disruptive behavior will be considered a Level 3 incident and forwarded to the Chief of Staff for further investigation and action as hereinafter set out. A commitment from the practitioner not to repeat the behavior shall, again, be required and a copy of the report will become a permanent part of practitioner's Performance Improvement file for further reference.

If a third incident of mild disruptive behavior occurs within the initial twenty-four (24) months and is found to be substantiated, the incident will be handled as a Level 3 as hereinafter set out.

If at any time, the CEO and Chief of Staff are unable to resolve the disruptive conduct with the practitioner, the CEO and the Chief of Staff may submit a report to the MEC for review and possible further action. This may include the initiation of an investigation or corrective action.

c) **Level 3** – A substantiated claim of disruptive behavior that is not not egregious and *does not present a direct risk to patient and/or staff* but which warrants further investigation by the Chief Executive Officer and the Chief of Staff or designee and consultation by the Chief of Staff with the practitioner involved for behavior modification (i.e.: disruptive behavior which does not directly affect patient care including, but not limited to, abusive or degrading comments which impair staff's ability to perform their responsibilities; a trend of three or more Level 2 incidents; etc.). The incident shall be investigated and, if substantiated by the Vice President, the Chief Executive Officer and the Chief of Staff or designee shall notify the practitioner and discuss the incident and assess the cause and significance of the incident. Based on the results of that discussion, ongoing monitoring of practitioner's behavior may be established to include, but may not be limited to, monitoring by the Medical Executive Committee and/or referral to the Colorado Physician Health Program, the Colorado Physician Education Program, and/or another qualified professional or agency as may be determined to be appropriate or necessary. If the substantiated incident is determined to be sufficiently egregious or a trend of repetitive behavior is identified, the practitioner may be suspended in accordance with the Medical Staff Bylaws and a copy of the report will become a permanent part of the practitioner's Performance Improvement file for further reference.

d) **Level 4** – A substantiated claim of an egregious incident (i.e.: physical or sexual harassment; assault; a fraudulent act; damaging or destruction of HRRMC property; or inappropriate physical behavior, etc.), repeated disruptive conduct, or conduct *that presents a direct risk to patients or hospital operations* will be reviewed by the CEO and require the investigation of the Chief of Staff and Medical Executive Committee and/or further action under the Medical Staff Bylaws as may be recommended by the Chief of Staff in consultation with the Medical Executive Committee. The incident, if substantiated, shall be discussed with the practitioner to assess the cause and significance of the incident. Based on the results of that discussion, further action may be taken including ongoing monitoring of practitioner's behavior by the Medical Staff or through a referral to the Colorado Physician Health Program, the Colorado Physician Education Program, and/or another qualified

professional or agency as may be determined to be appropriate or necessary. If the substantiated incident is determined to be sufficiently egregious or a trend of repetitive behavior is identified, the practitioner may be suspended in accordance with the Medical Staff Bylaws and a copy of the report will become a permanent part of practitioner's Performance Improvement file for further reference.

4. In the event there is a disagreement at any time in the level assigned to a particular claim either between HRRMC Administration, the Chief of Staff or designee, and/or the affected practitioner, the disagreement in level to be assigned to a particular claim shall be resolved by the Medical Executive Committee.

5. During any meeting with the practitioner referenced above, the practitioner shall be advised of the nature of the reported behavior and will be asked to respond. The goal of this meeting is to help the practitioner understand what conduct is inappropriate and unacceptable, and that such conduct is inconsistent with the policies of HRRMC. The practitioner shall be advised that any retaliation against the person(s) reporting the matter is grounds for disciplinary action. At this meeting, the practitioner may be advised of administrative channels available to him/her for registering complaints or concerns about quality or services. Other sources of support or counseling for the practitioner may be identified, as appropriate, including but not limited to the Colorado Physician Education Program and/or the Colorado Physician Health Program as may be determined to be necessary or appropriate. The practitioner will be advised that a summary of the meeting will be prepared and a copy provided to him/her. The practitioner may prepare a written response to the summary. Both the summary and the practitioner's response, if any, will be kept in the practitioner's confidential Performance Improvement file. The practitioner will also be given a copy of this Code of Conduct Policy and Professional Expectations at this meeting.
6. If the practitioner refuses to sign the agreement, the Chief of Staff and/or the Chief Executive Officer may refer the matter to the Medical Executive Committee for further action in accordance with the Medical Staff Bylaws.

7. All actions taken pursuant to this policy are for the purpose of ensuring safe patient care and, as part of the HRRMC's peer review process, shall be maintained in a confidential manner under the provisions of the Colorado peer review and quality assurance statutes which protect such information from discovery.

8. This policy may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff in the same manner as an amendment to the Medical Staff Bylaws or Medical Staff Rules & Regulations as reflected in Articles XVIII and XIX of the Medical Staff Bylaws.

APROVED: _____ DATE: 2/19/10
(Chief of Staff)

APPROVED: _____ DATE: 2/19/10
(Chief Executive Officer)

APPROVED: _____ DATE: 3/18/10
(Chairman, Board of Directors)

REVIEWED: _____ DATE: _____

REVIEWED: _____ DATE: _____

**Attestation by Applicant and/or Privileged Provider**

*My signature confirms that I have reviewed and agree to follow this Code of Conduct. I commit to the HRRMC mission, vision and values, as I interact with patients and the patient care team at HRRMC.*

*I have received a copy of Heart of the Rockies Regional Medical Center's Medical Staff Bylaws, Rules and Regulations, and associated Medical Staff Policies & Procedures and agree to abide by them.*

*Signature:* _____

*Please print name:* _____

*Date:* _____