

MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
Penrose-St. Francis Health Services

ALLIED HEALTH
PROFESSIONALS POLICY

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ARTICLE 1
GENERAL

1.A. DEFINITIONS

The definitions within this Manual are the same that are listed within the main Medical Staff Bylaws document.

1.B. TIME LIMITS

Time limits referred to in this Manual shall be the same as listed in the main Medical Staff Bylaws document.

1.C. DELEGATION OF FUNCTIONS

Provisions for delegation of function shall be the same in this manual as it is outlined in the main Medical Staff Bylaws document.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

- (1) This Policy addresses those Allied Health Professionals who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy.
- (2) This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2.B. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

- (1) Only those specific categories of Allied Health Professionals that have been approved by the Board shall be permitted to practice at the Hospital. All Allied Health Professionals who are addressed in this Policy shall be classified as either Category 1, Category 2, or Category 3 practitioners.
- (2) Below is a list of the specific categories of Allied Health Professionals functioning in the Hospital as Category 1, Category 2, and Category 3 practitioners. This list of approved specialties may be modified or supplemented by action of the Board, after receiving the recommendation of the MEC, without the necessity of further amendment of this Policy.

2.B.1. Category 1 – Licensed Independent Practitioners

The composition of Category 1 shall consist of:

Advance Practice Nurses (i.e. Nurse Practitioners, Clinical Nurse Specialist, Certified Nurse Midwife, and Certified Registered Nurse Anesthetist)
Psychology
Licensed Clinical Social Worker
Licensed Marriage and/or Family Therapist
Physical Therapist
Audiologist and Speech Pathologist

2.B.2. Category 2 – Advanced Licensed Dependent Practitioners

The composition of Category 2 shall consist of:

Physician Assistant

2.B.3. Category 3 – Licensed and Non-Licensed Dependent Practitioners

The composition of Category 3 shall consist of:

Registered Nurse
Licensed Practical Nurse
Medical Research Assistant
Neurodiagnostic Intraoperative Monitoring Technician
Surgical Assistant
Surgical Technician and Operating Room Scrub Technician
Dental Assistant
Orthopedic Technician
Pathology Assistant
Gross Technician
Embryologist
Prosthetic and Orthotic Fitting Technician

Cardiovascular Perfusionist and Cell Saver Technician
Radiology Assistant and Radiology Technician

2.C. PROCESS FOR DETERMINING NEED FOR A NEW CATEGORY OF ALLIED HEALTH PROFESSIONALS

2.C.1. Review of Need:

- (a) Whenever an Allied Health Professional requests to practice at the Hospital, and the Board has not already approved the category of practitioner for practice at the Hospital, the Credentials Committee shall evaluate the need for that category of Allied Health Professional. The Credentials Committee shall report to the MEC, which shall make a recommendation to the Board for final action.
- (b) As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, the reason access to the Hospital is sought, and the potential benefits to the community of having such services available at the Hospital.
- (c) The Credentials Committee may consider the following factors when making a recommendation as to the need for the services of a specific category of Allied Health Professional:
 - (1) the nature of the services that would be offered;
 - (2) any state license or regulation which outlines the specific patient care services and/or activities that the Allied Health Professional is authorized by law to perform;
 - (3) any state "nondiscrimination" or "any willing provider" laws that would apply to the Allied Health Professional;
 - (4) the patient care objectives of the Hospital, including patient convenience;
 - (5) the community's needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professional were provided at the Hospital;
 - (6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;
 - (7) the availability of supplies, equipment, and other necessary Hospital resources;
 - (8) the need for, and availability of, trained staff to support the services that would be offered; and
 - (9) the ability to appropriately supervise performance and monitor quality of care.

2.C.2. Additional Recommendations:

- (a) If the Credentials Committee makes a recommendation that there is a need for the particular category of Allied Health Professional at the Hospital, it shall also recommend:
 - (1) any specific qualifications and/or training that must be possessed beyond those set forth in this Policy;
 - (2) a detailed description of a scope of practice or clinical privileges;
 - (3) any specific conditions that apply to practice within the Hospital; and

- (4) any supervision requirements, if applicable.
- (b) In developing such recommendations, the Credentials Committee shall consult the appropriate department chair(s) and consider relevant state law and may contact professional societies or associations. The Credentials Committee may also recommend the number of Allied Health Professionals that are needed.

ARTICLE 3

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

3.A. QUALIFICATIONS

3.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial and continued permission to practice, Allied Health Professionals must, where applicable:

- (a) where applicable to specialty, successful completion of an accredited program or equivalent training in the primary field of practice and in accordance to Hospital's defined privileging criteria. Such requirements include:
 - i. a clinical psychology training program accredited by the American Psychological Association; or
 - ii. a masters or doctoral program for nurse midwifery accredited by the American College of Nurse-Midwives.
- (b) have a current, unrestricted license, certification, or registration to practice in Colorado and have never had a license, certification, or registration to practice revoked or suspended by any state agency;
- (c) where applicable to their practice, have a current, unrestricted DEA registration;
- (d) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill responsibilities and provide timely and continuous care for patients in the Hospital;
- (e) have current, valid professional liability coverage in a form and in amounts satisfactory to the Hospital;
- (f) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil monetary penalties for the same;
- (f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (g) have never had a scope of practice or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) have never relinquished or resigned affiliation, scope of practice, or clinical privileges during an investigation or in exchange for not conducting an investigation;
- (i) have never been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
- (j) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital; and
- (k) to the extent required by law, if seeking to practice as a Category 2 or Category 3 practitioner, have a written agreement with a Sponsoring Physician, which agreement must meet all applicable requirements of state law and Hospital policy.
- (l) health screenings and immunizations/vaccinations.

3.A.2. Waiver of Threshold Eligibility Criteria:

- (a) Any individual who does not satisfy a threshold eligibility criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, the MEC, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.
- (d) A determination that an individual is not entitled to a waiver is not a "denial" of a scope of practice or clinical privileges.

3.A.3. Factors for Evaluation:

The following factors will be evaluated as applicable, as part of a request for permission to practice:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, and responsible attitude toward patients, families, and their profession;
- (c) ability to safely and competently perform the clinical privileges or scope of practice requested;
- (d) good reputation and character;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

3.A.4. No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment unless otherwise provided for under this Policy.

3.A.5. Nondiscrimination Policy:

No individual shall be denied appointment or reappointment on the basis of gender, age, race, creed, national origin, physical or mental disability, which does not constitute an impairment to exercise requested privileges, and sexual orientation.

3.B. GENERAL CONDITIONS OF PRACTICE

3.B.1. Assumption of Duties and Responsibilities:

As a condition of being granted permission to practice and as a condition for continued permission to practice, Allied Health Professionals specifically agree to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all bylaws, policies, and rules and regulations of the Hospital and Medical Staff;
- (c) to accept committee assignments, participation in quality improvement and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;
- (d) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her specialty, including those related to national patient safety initiatives and core measures;
- (e) to comply with adopted protocols and pathways or document the clinical reasons for variance;
- (f) to maintain a current physical and e-mail address with the Medical Staff Office, which shall be the official mechanism used to communicate all information to the individual other than peer review information pertaining to the individual and/or protected health information of patients;
- (g) to inform the CEO or the Chief of Staff, in writing, of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, and shall include, but not be limited to:
 - changes in licensure status, DEA controlled substance authorization, or professional liability insurance coverage,
 - the filing of a professional liability lawsuit against the practitioner,
 - changes in the practitioner's status at any other hospital,
 - arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter,
 - exclusion or preclusion from participation in Medicare or any sanctions imposed, and
 - any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident shall be reviewed by the Chief of Staff and the CEO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they shall forward the matter for further review under the Practitioner Health Policy or this AHP Policy.);
- (h) to immediately submit to a blood, hair, and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of administration) are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders;
- (i) to appear for personal interviews as may be requested;
- (j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

- (k) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (l) to refrain from deceiving patients as to his or her status as an Allied Health Professional;
- (m) to seek consultation when appropriate;
- (n) to participate in monitoring and evaluation activities;
- (o) to complete, in a timely manner, all medical and other required records containing all information required by the Hospital;
- (p) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;
- (q) to satisfy applicable continuing education requirements;
- (r) to promptly pay any applicable dues and assessments; and
- (s) that any misstatement in, or omission from, the application form is grounds for the Hospital to stop processing the application. If permission to practice has been granted prior to the discovery of a misstatement or omission, clinical privileges or scope of practice may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to the procedural rights in Article 7 of this Policy.

3.B.2. Burden of Providing Information:

- (a) Allied Health Professionals seeking permission to practice 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 for resolving any doubts about such qualifications.
- (b) Allied Health Professionals seeking permission to practice at the Hospital have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the department chair, Credentials Committee, MEC, and/or Board request any new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) It is the responsibility of the individual seeking permission to practice at the Hospital to provide a complete application, including adequate responses from references. An incomplete application shall not be processed.

3.C. APPLICATION

3.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference. In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's scope of practice or clinical privileges and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subject to probationary or other

conditions, reduced, limited, terminated, or not renewed at any hospital or health care facility or is currently being investigated or challenged;

- (2) information as to whether the applicant's license or certification to practice any profession in any state or DEA registration or any state controlled substance license is, or has ever been, voluntarily or involuntarily relinquished, suspended, modified, terminated, or restricted or is currently being investigated or challenged;
- (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments or settlements, and the substance of the allegations, as well as the findings and the ultimate disposition;
- (4) current information regarding the applicant's ability to safely and competently exercise the scope of practice or clinical privileges he or she has requested; and
- (5) a legible copy of a government-issued photo identification.
- (6) The applicant shall sign the application and certify that he or she is able to perform the scope of practice or clinical privileges requested and the responsibilities of Allied Health Professionals.

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

By requesting an application and/or applying for permission to practice, the individual expressly accepts the following conditions:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to permission to practice, clinical privileges, or scope of practice, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued authorization to practice at the Hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for permission to practice, clinical privileges

or scope of practice, and/or participation at the requesting organization/facility, and any licensure or regulatory matter. The specific process for release of information shall be coordinated by the Medical Staff Office.

(d) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Scope of Section:

All of the provisions in this Section 3.C.2 are applicable in the following situations:

- (i) whether or not permission to practice and clinical privileges or scope of practice are granted;
- (ii) throughout the term of any affiliation with the Hospital and thereafter;
- (iii) should permission to practice or clinical privileges or scope of practice be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
- (iv) as applicable, to any third-party inquiries received after the individual leaves the Hospital about his/her tenure at the Hospital.

ARTICLE 4

CREDENTIALING PROCEDURE

4.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

4.A.1. Request for Application:

- (a) Any individual requesting an application for permission to practice as an Allied Health Professional in an approved category shall be sent the application form. An individual who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 7 of this Policy.

4.A.2. Initial Review of Application:

- (a) A completed application, with copies of all required documents, must be returned to the Medical Staff Office or designated Credentials Verification Office ("CVO"). The application must be accompanied by the application processing fee.
- (b) As a preliminary step, the Medical Staff Office shall review the application to determine that the individual satisfies all threshold criteria. An individual who fails to meet the eligibility criteria set forth in Section 3.A.1 of this Policy shall be notified that his or her application shall not be processed. A determination of ineligibility does not entitle an individual to the procedural rights outlined in Article 7 of this Policy.
- (c) The Medical Staff Office or CVO shall also review the application to determine if all questions have been answered, all references and other information or materials have been received, and pertinent information provided on the application has been verified with primary sources. If an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable department chair.

4.A.3. Review by Department Chair:

- (a) The Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate department chair. Each chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for the scope of practice or clinical privileges requested.
- (b) In preparing this report, the department chair has the right to meet with the applicant, and the Sponsoring Physician (if applicable), to discuss any aspect of the application, qualifications, and requested scope of practice or clinical privileges. The department chair may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, appropriate supervisor within the department, nurse managers).
- (c) The department chair shall be available to answer any questions that may be raised with respect to that chair's report and findings.

4.A.4. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the department chair and may interview the applicant. Thereafter, the Credentials Committee shall make a recommendation.
- (b) The Credentials Committee may require the applicant to undergo a physical and/or mental health examination by a physician(s) or recognized health program satisfactory to the Committee. The results of this examination shall be made available to the Credentials Committee for its consideration. Failure of an applicant to undergo an

examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

- (c) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.
- (d) The Credentials Committee's recommendation shall be forwarded to the MEC or the Chief of Staff, as applicable.

4.A.5. MEC Recommendation:

- (a) At its next regular meeting after receipt of the written findings and recommendations of the Credentials Committee, the MEC shall:
 - (1) adopt the findings and recommendations of the Credentials Committee; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the MEC is favorable, the recommendation shall be forwarded to the Board.
- (c) If the recommendation of the MEC would entitle the applicant to the procedural rights set forth in Article 7, the CEO shall send the applicant special notice. The CEO shall then hold the application until after the applicant has completed or waived the procedural process outlined in this Policy.

4.A.6. Board Action:

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

Any decision reached by the Board committee to grant the clinical privileges requested shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

- (b) When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted clinical privileges requested, the Board may:
 - (1) grant the applicant the clinical privileges as recommended; or

- (2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chief of Staff. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

4.B. PERIOD TO CONFIRM COMPETENCE

4.B.1. Nature of Period to Confirm Competence:

Initial appointment to the Allied Health categories 1 and 2 and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused review in order to confirm competence.

4.B.2. Focused Professional Practice Evaluation:

During the period to review competence, the individual's exercise of the relevant clinical privileges will be evaluated by the chair of the department in which the individual has clinical privileges and/or by a physician(s) designated by the Credentials Committee. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review, and information obtained from other allied health professionals, physicians and Hospital employees. The numbers and types of cases to be reviewed shall be determined by the Credentials Committee. The duration of the provisional period for all other initial grants of privileges will be as recommended by the Credentials Committee.

4.B.3. Duties During Period to Review Competence:

- (a) During the period to review competence, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases or other activities to be reviewed by the department chair and/or by other designated physicians.
- (b) A new member of the Allied Health shall automatically relinquish his or her appointment and privileges at the end of the provisional period if that new member fails, during the period, to:
 - (1) participate in the required number of cases (as applicable);
 - (2) cooperate with the monitoring and review conditions; or
 - (3) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities.

In such case, the individual may not reapply for initial appointment or privileges for two years.

- (c) If an Allied Health Professional, who has been granted additional clinical privileges fails, during the review period, to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period unless otherwise determined by the Credentials Committee.
- (d) When, based on the evaluation performed during the review period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the individual shall be entitled to a hearing and appeal.

4.C. CLINICAL PRIVILEGES

4.C.1. General:

The clinical privileges recommended to the Board for Category 1 and Category 2 Practitioners will be based upon consideration of the following factors: Article 4.A.1.

- (a) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to the same;
- (b) ability to perform the privileges requested competently and safely;
- (c) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;
- (d) adequate professional liability insurance coverage for the clinical privileges requested;
- (e) the Hospital's available resources and personnel;
- (f) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
- (g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
- (h) practitioner-specific data as compared to aggregate data, when available and when statistically and qualitatively significant and meaningful;
- (i) morbidity and mortality data related to the specific individual, when available; and
- (j) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

4.D. TEMPORARY CLINICAL PRIVILEGES

4.D.1. Request for Temporary Clinical Privileges:

- (a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO, upon recommendation of the Chief of Staff, Chair of the Credentials Committee, Chief of the applicable department, or CMO under the following conditions:
 - (1) the applicant has submitted a complete application, along with the application fee, if applicable;
 - (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank and from a criminal background check;
 - (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he/she has not been subject to involuntary termination of Allied Health membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility, and (2i) all references contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;
 - (4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Credentials Committee after considering the evaluation of the department chair; and

- (5) temporary privileges for an Allied Health Staff applicant shall be granted for a maximum period of 120 consecutive days.
- (b) Other. Temporary privileges may also be granted in other limited situations by the CEO, upon recommendation of the Chief of Staff, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:
 - (1) the care of a specific patient;
 - (2) when a proctoring or consulting physician is needed, but otherwise unavailable; or
 - (3) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors shall be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank. The grant of clinical privileges in these situations shall not exceed 120 days. In exceptional situations, this period of time may be extended in the discretion of the CEO and the Chief of Staff. Requests by an individual practitioner for temporary privileges cannot exceed more than two (2) in a calendar year.

- (d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

4.D.2. Termination of Temporary Clinical Privileges:

- (a) The CEO may, at any time after consulting with the Chief of Staff, the Chair of the Credentials Committee or the department chair, terminate temporary privileges for any reason.
- (b) The granting of temporary privileges is a courtesy. Neither the denial nor termination of temporary privileges shall entitle the individual to the procedural rights set forth in Article 7.

4.E. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

4.E.1. Submission of Application:

- (a) The grant of a scope of practice or clinical privileges shall be for a period not to exceed two years. A request to renew a scope of practice or clinical privileges shall be considered only upon submission of a completed renewal application.
- (b) At least five months prior to the date of expiration of an Allied Health Professional's scope of practice or clinical privileges, the Medical Staff Office or CVO shall notify the individual of the date of expiration and provide the individual with a renewal application.
- (c) Failure to return a completed application at least four months prior to the expiration of the individual's scope of practice or clinical privileges may result in the assessment of a renewal late fee. In addition, failure to submit the complete application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of such scope of practice or clinical privileges at the end of the then current term, unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office/CVO and the Medical Staff leaders.

- (d) Once an application for renewal of scope of practice or clinical privileges has been completed and submitted to the Medical Staff Office, it shall be evaluated following the same procedures outlined in this Policy regarding initial applications.

4.E.2. Renewal Process for Category 1 and Category 2 Practitioners:

- (a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, shall be applicable in processing requests for renewal for these practitioners.
- (b) As part of the process for renewal of clinical privileges, the following factors shall be considered:
 - (1) an assessment prepared by the applicable department chair;
 - (2) an assessment prepared by a peer, if possible;
 - (3) results of the Hospital's performance improvement and peer review activities, taking into consideration, when applicable, practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
 - (4) resolution of any verified complaints received from patients or staff; and
 - (5) any focused professional practice evaluations; and
 - (6) any other information deemed necessary.

4.E.3. Renewal Process for Category 3 Practitioners:

- (a) The procedures pertaining to an initial request for a scope of practice, including eligibility criteria and factors for evaluation, shall be applicable in processing requests for renewal for these practitioners.
- (b) As part of the process for renewal of scope of practice, the following factors shall be considered:
 - (1) the annual competency assessments of the individual performed by the Sponsoring Physician(s) and/or the applicable Hospital department heads (i.e., OR Supervisor, Nursing Supervisor); and
 - (2) resolution of any verified complaints received from patients or staff; and
 - (3) any other information deemed necessary.

ARTICLE 5

CONDITIONS OF PRACTICE APPLICABLE TO CATEGORY 2 AND CATEGORY 3 PRACTITIONERS

5.A. OVERSIGHT BY SUPERVISING / SPONSORING PHYSICIAN

- (1) Category 2 and Category 3 practitioners may function in the Hospital only so long as they have a Sponsoring Physician.
- (2) Any activities permitted to be performed at the Hospital by a Category 2 and Category 3 practitioner shall be performed only under the supervision or direction of the Supervising / Sponsoring Physician.
- (3) If the Medical Staff appointment or clinical privileges of a Supervising / Sponsoring Physician are resigned, revoked or terminated, the Category 3 practitioner's scope of practice or Category 2 practitioner's clinical privileges shall be automatically relinquished. The Credentials Committee may, however, recommend that the Category 2 or Category 3 practitioner be permitted to arrange for another Supervising / Sponsoring Physician who is on the Medical Staff.
- (4) As a condition of a scope of practice or clinical privileges, a Category 2 or Category 3 practitioner and the Supervising / Sponsoring Physician must provide the Hospital with notice of any revisions or modifications that are made to the supervision agreement. This notice must be provided to the CEO within three days of any such change.

5.B. QUESTIONS REGARDING THE AUTHORITY OF CATEGORY 2 AND CATEGORY 3 PRACTITIONERS

- (1) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of a Category 2 or Category 3 practitioner to act or issue instructions outside the presence of the Sponsoring Physician, such individual shall have the right to request that the Sponsoring Physician validate, either at the time or later, the instructions of the Category 2 or Category 3 practitioner. Any act or instruction of the Category 2 or Category 3 practitioner shall be delayed until such time as the individual with the question has ascertained that the act is clearly within the scope of practice granted to the individual.
- (2) Any question regarding the conduct of a Category 2 and Category 3 practitioner shall be reported to the Chief of Staff, the Chair of the Credentials Committee, the relevant department chair, the CMO, or the CEO for appropriate action. The individual to whom the concern has been reported shall also discuss the matter with the Sponsoring Physician.

5.C. RESPONSIBILITIES OF SPONSORING PHYSICIAN

- (1) The Sponsoring Physician shall remain responsible for all care provided by the Category 2 and Category 3 practitioner in the Hospital.
- (2) The number of Category 2 and/or Category 3 practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, shall be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Sponsoring Physician shall make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Category 2 or Category 3 practitioner, to the extent that such filings are required.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

6.A. COLLEGIAL INTERVENTION

- (1) As part of the Hospital's performance improvement and professional practice evaluation activities, this Policy encourages the use of collegial efforts and progressive steps by Medical Staff leaders and administration to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff leaders.
- (2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.
- (3) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review activities. Such interventions and evaluations are not mandatory prerequisites to MEC review.
- (4) The Chief of Staff, in conjunction with the CEO and/or CMO, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., policy on practitioner health, code of conduct policy, professional practice evaluation policy) or to direct the matter to the MEC for further review and/or investigation.

6.B. INVESTIGATIONS

6.B.1. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner.

6.B.2. Investigative Procedure:

- (a) The MEC shall either investigate the matter itself, request that it be conducted by the Credentials Committee, or appoint an ad hoc committee to conduct the investigation ("investigating committee"). The investigating committee will not include relatives or financial partners of the Allied Health Professional or the Allied Health Professional's Sponsoring Physician (where applicable).
- (b) The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital.
- (c) The investigating committee will also have the authority to use outside consultants, if needed.
- (d) The investigating committee may require a physical and/or mental examination of the individual by a health care professional(s) acceptable to it.
- (e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

- (f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.
- (g) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

6.B.3. Recommendation:

- (a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose a requirement for monitoring or consultation;
 - (4) recommend or impose a requirement for additional training or education;
 - (5) recommend reduction of clinical privileges or scope of practice;
 - (6) recommend suspension of clinical privileges or scope of practice for a term;
 - (7) recommend revocation of clinical privileges or scope of practice; or
 - (8) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the CEO, who will promptly inform the individual by special notice. The CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.
- (d) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.C. ADMINISTRATIVE SUSPENSION automatic relinquishment (match physicians)

- (1) The CEO, the CMO, the Chief of Staff, and/or the appropriate department chair shall each have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any Allied Health Professional whenever a question has been raised about such individual's clinical care or professional conduct.
- (2) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the Chief of Staff, and shall remain in effect unless or until modified by the CEO or the MEC. The imposition of an administrative suspension does not entitle an Allied Health Professional to the procedural rights set forth in Article 7 of this Policy.
- (3) Upon receipt of notice of the imposition of an administrative suspension, the CEO and Chief of Staff shall forward the matter to the MEC which shall review and consider the question(s) raised and thereafter make a recommendation to the Board.

6.D. AUTOMATIC RELINQUISHMENT OF SCOPE OF PRACTICE OR CLINICAL PRIVILEGES

- (1) The scope of practice or clinical privileges of an Allied Health Professional shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:
 - (a) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 3.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;
 - (b) the Allied Health Professional is arrested, charged, indicted, convicted, or enters a plea of guilty or no contest to any felony; or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) alcohol; (iv) Medicare, Medicaid, or insurance or health care fraud or abuse; or (v) violence.
 - (c) the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges, in response to a written request from the Credentials Committee, the MEC, the CEO, or any other committee authorized to request such information;
 - (d) a determination is made that there is no longer a need for the services of a particular discipline or category of Allied Health Professional; or
 - (e) the Category 2 or Category 3 practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Sponsoring Physician as defined in this Policy.
- (2) Requests for reinstatement shall be reviewed by the relevant department chair, the Chair of the Credentials Committee, the Chief of Staff, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

6.E. LEAVE OF ABSENCE

- (1) An Allied Health Professional may request a leave of absence by submitting a written request to the Chief of Staff. Except in extraordinary circumstances, this request shall be submitted at least 30 days prior to the anticipated start of the leave. The request shall state the beginning and the anticipated ending dates of the leave, which shall not exceed one year, and the reasons for the leave. Members of the Allied Health Staff requesting a Leave of Absence for military duty may be exempt from the one-year requirement.
- (2) An Allied Health Professional must report to the Chief of Staff any time they are away from medical staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Certain circumstances may trigger an automatic medical leave of absence.
- (3) In determining whether to grant a request for a leave of absence, the Chief of Staff with the relevant department chair shall consult. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records. The Chief of Staff shall determine whether a request for a leave of absence shall be granted.

- (4) During the leave of absence, the individual shall not exercise any clinical privileges.
- (5) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. [\(Policy regarding Criteria for Return from Leave of Absence\)](#) Requests for reinstatement shall then be reviewed by the relevant department chair, the Chair of the Credentials Committee, the Chief of Staff, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.
- (6) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by an appropriate report from the individual's health care practitioner indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- (7) Absence for longer than one year shall result in automatic relinquishment of appointment and clinical privileges unless an extension is granted by the Chief of Staff. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Staff and Hospital.
- (8) If an individual's current appointment is due to expire during the leave, the reappointment must be processed within the specified time frame or the individual's appointment and clinical privileges shall lapse at the end of the appointment period, and the individual shall be required to apply as a new appointment.
- (9) Leave of Absence is a matter of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE 7

PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all rights to which Allied Health Professionals are entitled are set forth in this Policy.

7.A. PROCEDURAL RIGHTS FOR CATEGORY 3 PRACTITIONERS

- (1) In the event a recommendation is made by the MEC or the Chief of Staff that a AHP not be granted a scope of practice/clinical privileges or that a scope of practice/clinical privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual shall receive special notice of the recommendation. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a hearing with the MEC or the Chief of Staff, depending upon who made the recommendation.
- (2) If a hearing is requested, the hearing shall be scheduled to take place within a reasonable time frame. The hearing shall be informal. The Sponsoring Physician and the AHP shall both be permitted to attend this hearing. However, no counsel for either party shall be present.
- (3) Following this hearing, the Chief of Staff or the MEC, depending upon who made the initial recommendation, shall make a final decision.
- (4) Within 10 days after the final decision the AHP may submit a written appeal of the final decision to the CEO. The CEO shall respond in writing within a reasonable time frame.

ARTICLE 8

HOSPITAL EMPLOYEES

- A. Except as provided below, the employment of an Allied Health Professional by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions, and terms of the individual's employment relationship and/or written contract shall apply.
- B. A request for a scope of practice/clinical privileges, on an initial basis or for renewal, submitted by a AHP who is seeking employment or who is employed by the Hospital, shall be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications shall be made to Administration or Human Resources (as appropriate) to assist the Hospital in making employment decisions.
- C. If a concern about an employed Allied Health Professional's clinical conduct or competence originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 6 and 7 of this Policy, after which a report will be provided to Human Resources.

ARTICLE 9
AMENDMENTS

This Policy is part of the Medical Staff Bylaws and is subject to the amendment provisions set forth therein as they may be amended from time to time.

ARTICLE 10
ADOPTION

This Allied Health Professionals Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules, regulations, policies, or manuals pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____ (Date) _____

Approved by the Board: _____ (Date) _____