A description of medical staff credentialing and privileging at SMHMC is contained in the medical staff bylaws. This Credentials Procedure Policy describes the associated details that facilitate the implementation of these activities.

1.1 Eligibility and Qualifications
1.2 Conditions and Duration of Appointment
1.3 Leave of Absence (LOA)
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4.1 Exclusive Agreements
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ARTICLE I MEDICAL STAFF MEMBERSHIP

1.1 ELIGIBILITY AND QUALIFICATIONS FOR MEMBERSHIP

The basic eligibility criteria and qualifications for membership on the medical staff of the Hospital are found in Volume I of the Medical Staff Bylaws in Article II, Section 2.1. In addition, the Board may impose further requirements on specific practitioners where it believes these are warranted after a review of the practitioner’s credentials file, performance data, or other relevant material.

1.2 CONDITIONS AND DURATION OF APPOINTMENT

1.2.1 Initial Appointment and Reappointment

a) Initial appointment and reappointment to the medical staff shall be made by the Hospital Board. The Board shall act on appointments and reappointments only after there has been a recommendation or an opportunity for a recommendation from the MEC.

b) Appointment to the medical staff will be for a period up to twenty-four (24) calendar months. c) Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted by the Board.

1.2.2 Reapplication After Modifications of Membership Status or Privileges

A practitioner who has received a final adverse decision by the Board regarding membership or privileges, or who has resigned or withdrawn an application for appointment or reappointment or privileges while under Investigation or to avoid Investigation, will be ineligible to reapply to the medical staff or for privileges for a period of four (4) years from the date of such resignation or withdrawal or the date of notice of a final adverse action by the Board.

1.3 LEAVE OF ABSENCE (LOA)

1.3.1 Written Notice

When a practitioner will be absent from the active practice of medicine in Grand Junction for a period of greater than ninety days, the practitioner must request a leave of absence from the medical staff. Such request shall be received in the medical staff office thirty (30) days prior to the requested leave date whenever practicable. The request shall state the reason the medical staff member is asking for the leave and the exact period of leave time requested, which may not exceed one (1) year (exclusive of the time necessary to process an initial request or a request for reinstatement). Such request shall be submitted to the medical staff Credentials Committee and MEC, which shall review such requests and recommend approval or disapproval to the Governing Board. The Hospital Board shall make the final decision whether to approve or disapprove such request. Requests for a leave of absence will not be considered if the requesting member is under Investigation, as described in Volume II, Corrective Action and Fair Hearing Manual of the Bylaws. In the event that a request for a leave of absence is approved, the medical staff member shall make necessary arrangements to provide alternate coverage for necessary and proper patient care during his absence and shall meet all obligations listed in 1.3.2 below. During the period of a leave, the staff member’s membership status, privileges and prerogatives, duty to pay medical staff dues, if any, and attendance requirements at medical staff meetings shall be suspended. In the event that the Board disapproves the request for a leave of absence, the affected staff member shall not be entitled to procedural rights unless otherwise provided in Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws.
1.3.2 **Obligations**

A request for leave of absence shall not be considered until all obligations to the Hospital have been met, including completion of all medical records, payment of any outstanding dues, and fulfillment of any Emergency Department or other call obligations.

1.3.3 **Request to Return from LOA**

Not less than thirty (30) days prior to the termination of the leave, the medical staff member must request, in writing, reinstatement of his/her membership and/or privileges and submit such request to the Hospital medical staff office. The medical staff member must also submit a written summary of his/her relevant activities during the leave if so requested by members of the Credentials Committee or MEC. Reinstatement will be made by action of the MEC. Prior to taking action the MEC may require the member to undertake a medical evaluation if the reason for the LOA was related to physical or mental illness. If the MEC denies reinstatement, the matter will be forwarded to the Board for a final decision. If the requested return date is past the time for the member’s reappointment, he or she must submit a reapplication form and be reappointed by the Board before resuming his or her staff position and privileges.

1.3.4 **Failure to Request to Return from LOA**

The failure of a medical staff member to request reinstatement from a LOA shall be deemed a resignation of medical staff membership status and privileges. The affected practitioner shall not be entitled to procedural rights as outlined in the Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws.

1.3.5 **Impact of Adverse Actions and Recommendations** A leave of absence will not impact or interfere with any adverse action or recommendation with respect to the medical staff member requesting the leave of absence.
1.4 PHYSICAL HEALTH STATUS

1.4.1 Health Requirements

Members of the medical staff and practitioners holding privileges must maintain the physical and mental ability to deliver patient care and exercise privileges safely and at an appropriate level of quality at all times.

1.4.2 Notification of Health Status

A medical staff member or practitioner holding privileges at SMHMC must immediately report in writing to the Hospital Vice President for Medical Affairs (VPMA) when he has a mental or physical condition that has the potential or likelihood to impair judgment or affect functional capability to perform granted privileges safely and at an appropriate level of quality at all times (as determined by the practitioner, a treating or evaluating physician, or a health care facility). Failure to do so may result in corrective action.

1.4.3 Health Examination

At any time that there is any reason to question whether a practitioner has the requisite physical and/or mental health status to care for patients safely and with an appropriate level of care and skill, the MEC or Hospital Board may require that practitioner to undergo an appropriate health examination. The nature and scope of the exam (including drug testing) and the examining clinician may be determined at the discretion of the MEC and/or VPMA. Where there is a concern that a practitioner may be impaired by current use of or addiction to drugs or alcohol, such examination may include the imposition of random drug or alcohol testing. Refusal of a practitioner to comply with a requested health examination will be considered a voluntary resignation from the medical staff and/or relinquishment of privileges.

ARTICLE II

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

2.1 GENERAL PROCEDURE

The medical staff through designated committees and officers shall evaluate and consider each application for appointment or reappointment and clinical privileges and each request for modification of staff membership or privileges and shall adopt and transmit recommendations to the Hospital Board. In the processing of applications for membership and privileges, references to Hospital shall include the SMHMC medical staff office and its personnel.
2.2 CONFIDENTIALITY

The credentialing processes carried out by the medical staff of SMHMC are considered peer review activities entitled to all available protections of federal and state law. All parties engaged in medical staff credentialing activities shall do so in a manner consistent with medical staff and Hospital confidentiality policies, and keep in strict confidence all papers, reports, and information obtained by virtue of their participation in the credentialing process.

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

Individual practitioners may review their own credentials file under the following circumstances and in a manner consistent with any policy adopted by the medical staff on access to peer review or credentials files:

After a request by the practitioner which is authorized by the Credentials Committee chair, a medical staff officer, or the VPMA. Review of such files will be conducted in the Hospital medical staff office and in the presence of a medical staff officer, or a designee of Hospital administration. Confidential letters of reference or complaint may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. A practitioner reviewing his file may not remove or alter any of the contents of the file. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of any review.

2.3 APPLICATION FOR INITIAL APPOINTMENT

2.3.1 Application Request Form and Application Form

Any qualified practitioner who wishes to apply for membership on the medical staff shall contact the Hospital to request an application. Each application for appointment to the medical staff shall be in writing, submitted on the prescribed form issued by the Hospital and signed by the applicant.

Upon request for an application, the medical staff office will forward the practitioner an application request form as well as an application for appointment to the medical staff and/or request for clinical privileges. The packet will also contain a complete set or overview of the Medical Staff Bylaws, rules and regulations, policies and procedures, and other required documents or reference to an electronic source for this information. The information provided to the applicant will enumerate the eligibility requirements for medical staff membership and/or privileges and a list of expectations of performance for individuals granted medical staff membership and/or privileges (if such expectations have been adopted by the medical staff).
If the applicant believes he meets the outlined eligibility criteria, he will so attest by signing the application request form and then may complete the application and return both documents along with applicable delineation of privilege forms to the medical staff office. Upon receipt of the application request form, the information provided will be reviewed to determine the applicant’s eligibility to apply for membership and/or privileges. If it is determined that the applicant is not eligible to apply, the applicant will be so informed and no further processing of the application will take place. If it is determined the applicant is eligible to apply, the submitted application will be processed.

2.3.2 **Content of Application Form:**

The application for appointment shall be in a form determined by the Hospital in consultation with the Medical Staff Credentials Committee and MEC. The completed application and its attachments shall include, but are not limited to, the following information:

a) **Acknowledgement and Agreement:** A statement signed by the applicant to the effect that he or she has received or been given access to (in paper or electronic form) and agrees to be bound by the Bylaws and any medical staff policies or procedures that are provided to the applicant as part of the application process. The applicant also agrees to be bound by these documents in all matters relating to consideration of his application whether or not he is granted membership and/or clinical privileges. Furthermore, the applicant agrees that if he is granted medical staff membership and/or privileges, he agrees to follow and be bound by any and all medical staff and Hospital policies and meet all the responsibilities of medical staff membership.

b) **Qualifications:** Detailed information concerning the applicant’s qualifications, including information in order to satisfy the Basic Eligibility and Qualifications of Medical Staff Membership (Article II of the Bylaws) and of any additional qualifications necessary to be granted any privileges requested.

c) **Requests:** Specific requests stating the clinical service and the privileges for which the applicant wishes to be considered. The applicant shall be eligible to request only those privileges for a clinical service the Board has authorized the Hospital to perform.

d) **Peer References:** The names of at least three (3) practitioners in the same professional discipline as the applicant who have worked with the applicant and observed his professional performance and who can provide references as to the applicant’s professional ability and judgment, ethical character, and ability to work cooperatively with other practitioners and Hospital personnel, such that patients treated by him receive quality care delivered in a professional and efficient manner. Information provided by the reference should address the applicant’s medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. In general, peer references should be submitted on a peer reference form provided by the Hospital and/or the reference should answer specific questions posed on this form.
e) **Ethical Pledge:** A pledge signed by the applicant agreeing to provide professional services in an ethical manner and to adhere to generally recognized professional ethics, the Medical Staff Code of Conduct Policy, and the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops.

f) **Professional Sanctions:** Information as to whether the applicant’s membership status and/or medical staff privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation not applicable to all other practitioners in the same medical staff category, or not renewed at any other Hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

- ☐ membership/fellowship in a local, state or national professional organization;
- ☐ staff membership status or clinical privileges at any other hospital or health care institutions;
- ☐ specialty board certification;
- ☐ licensure to practice any profession in any jurisdiction;
- ☐ Drug Enforcement (DEA) registration or a state controlled substance license; or
- ☐ information as to any current or pending sanctions, affecting participation in any Federal Healthcare Program or any actions which cause the practitioner to become ineligible for such programs.

If any such actions were ever taken or if any such actions are currently pending, the particulars of these actions shall be included.

g) **Criminal Proceedings:** Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

h) **Felony Convictions:** Information as to whether the applicant has ever been convicted of a felony or submitted a plea of guilty or no contest, if a felony prosecution is now pending against the applicant, and the particulars of any such conviction, settlement or prosecution, if any.

i) **History of Medical Staff Membership:** A chronological history listing all of the applicant’s past medical staff memberships and associated privileges, including the full addresses of the facilities at which such memberships or privileges were held.

j) **Professional Employment History:** A chronological history of applicant’s entire employment history as a health care professional.
k) **Education and Training History:** A chronological history of the applicant’s undergraduate education, all graduate education in the health care field, and all post-graduate training (internships/residencies) in a health care field.

l) **Notification of Release and Immunity Statement:** Such releases, waivers, and authorizations as are presented to the applicant by the Hospital. These will include a statement signed by the applicant authorizing and consenting to allow medical staff and Hospital representatives to provide other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any relevant information the Hospital or medical staff may have concerning the applicant. This statement will also release from liability the Hospital, its medical staff, and their representatives for sharing with appropriate health care and licensing entities information concerning the professional competence, ethics, and other qualifications of the applicant for staff appointment and privileges, including information otherwise privileged or confidential, to the full extent permitted by Colorado law. The applicant promises not to sue and to hold harmless all individuals who either provide information from or to the Hospital pertaining to the evaluation of the application, reapplication or privileges being requested or evaluated.

m) **Professional Liability Actions:** Particulars regarding medical malpractice claims filed against the applicant, any adverse and/or pending malpractice decisions or settlements, and information concerning any cancellation, non-renewal, or limitation of malpractice insurance coverage.

n) **Miscellaneous Information:** Such other information relating to evaluation of the applicant’s professional qualifications, ethical character and professional conduct, current competence, and prior professional experience, including utilization of Hospital resources, as may be deemed relevant by the MEC and the Hospital Board.

o) **Minimum Basic Criteria:** The following basic criteria must be appropriately documented and the information reasonably confirmed:

1) **Evidence of Current Licensure:** (unrestricted Colorado State License, unrestricted federal DEA as appropriate to specialty). Licensure is verified with the primary source.

2) **Relevant Training and/or Experience:** At the time of appointment and initial granting of clinical Privileges, the Hospital may require verification of relevant training or experience from the primary source(s), when feasible.

3) **Current Competence:** Recent letters of verification from the applicant’s residency program director or designee if residency training was within ten (10) years of initial application. Confirmation of board certification or qualification for certification from the appropriate specialty board. Written documentation from individuals personally acquainted first hand with the applicant’s recent professional and clinical performance including, if available and applicable, types of surgical procedures performed, outcomes for invasive procedures performed, types of medical conditions managed as the responsible physician, clinical knowledge, judgment and technical skills, and professional conduct.
4) **Ability to Perform Privileges Requested (Health Status):** A health status statement provided by the Hospital and signed by the applicant indicating that no physical or mental health problems exist that prevent the applicant from performing the requested clinical privileges with or without reasonable accommodation. This document may be confirmed by the director of the applicant’s training program, a chief of service or medical staff president at another hospital, or a qualified physician who has examined the applicant.

5) Possession of current, valid professional liability insurance that covers all privileges requested with an insurance carrier authorized by the State of Colorado Department of Insurance as a licensed provider of professional malpractice insurance. Insurance must be carried in a form and amount as determined from time to time by the Board, and in no event less than $1 million/$3 million dollars aggregate coverage;

6) Have a practice or residence close enough to the Hospital to provide timely and continuous care for their patients as determined by the Board;

7) Be eligible to participate in Medicare, Medicaid, and other federally sponsored health programs;

8) Be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect at all times. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations;

9) Provide a government issued photo identification document and a digital image of the applicant.

The Board may approve exceptions to the above Section 2.3.2 (p) on a case-by-case basis and after consultation with the MEC.

2.4 **APPLICATION FEE**

A non-refundable fee, in an amount established by the MEC and ratified by the Board, shall be payable upon request at the time of application for appointment or reappointment. Applications submitted without an accompanying fee will not be accepted for processing.
2.5 EFFECT OF APPLICATION

By applying for appointment to the medical staff, the applicant:

a) Agrees to provide in a timely fashion any information to complete the application and to resolve any questions relating to his application that are requested or posed by medical staff, Hospital, or Board representatives. A completed application must be signed and dated and must include: a current picture ID card issued by a state or federal agency; copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency; a completed privilege delineation form; completed reference forms from peers knowledgeable about the applicant’s competence to perform the privileges being requested; practitioner specific quality and clinical outcome data if available; all applicable fees.

b) Agrees to appear for interview(s) upon request.

c) Authorizes Hospital representatives to consult with other hospitals and medical staffs that have been associated with the applicant and with anyone who may have information bearing on the applicant’s clinical competence and qualifications for medical staff membership or privileges.

d) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his professional and ethical qualifications for staff membership.

e) Agrees that in the event of any adverse recommendations or decisions with respect to staff membership or privileges, as defined in these Bylaws, the applicant shall exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

f) Releases from liability all individuals and organizations that provide information, including otherwise legally privileged or confidential information to Hospital representatives concerning the applicant’s competence, professional ethics, character, physical and mental health, professional conduct, and other qualifications for staff appointment and clinical privileges.

g) Signifies that the information submitted in his application is true to the best of his knowledge and belief and that he/she understands that any significant misstatement(s) on or omission(s) from his application shall constitute grounds for rejection of the application.

h) Consents to and authorizes the production of information to third parties that query the Hospital about the applicant for credentialing/peer review purposes (e.g. Hospitals, insurance or managed care organizations, credentialing verification organizations, and state medical boards).
i) Agrees to provide to the Hospital medical staff office any requested information needed to process the application within forty-five (45) days of request or the application will be considered to be voluntarily withdrawn.

2.6 PROCESSING OF INITIAL APPLICATIONS

2.6.1 Applicant’s Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of his or her experience, background, training, clinical competence, and ability to adequately perform the privileges requested, and of resolving any doubts about these or any of the other qualifications specified in the Medical Staff Bylaws or in their associated Medical Staff manuals or policies. The applicant must be able to demonstrate to the satisfaction of the MEC and Board proficiency in the following six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. An application will not be processed by the Medical Staff until it is deemed complete by the Hospital medical staff office. If a medical staff committee, or the Board request additional information from the applicant to process the application, the application will be deemed incomplete. If the application remains incomplete for more than sixty days, it will be considered voluntarily withdrawn by the Practitioner who submitted the application.

2.6.2 Applicant Interview

All applicants for appointment to the medical staff and/or clinical privileges may be required to participate in an interview at the discretion of the Medical Staff Credentials Committee, MEC, or Board. The interview may take place in person or by telephone, video or computer link at the discretion of the party calling for the interview. The interview will be used to gather information about the applicant, to ask clinical questions pertaining to the privileges being requested and to communicate information to the applicant concerning medical staff responsibilities and expectations.

2.6.3 Verification of Information

The applicant shall deliver a completed application to the Hospital, which shall in a timely fashion, seek to collect or verify the references, licensure, and other qualifications evidence submitted. The Hospital shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant’s obligation to obtain the required information and provide it to the Hospital in a timely manner. Once collection and verification is completed, the Hospital shall forward a complete verified application and supporting materials to the Credentials Committee.
If the requirements for membership and/or privileges enumerated in this policy and the Medical Staff Bylaws are not met, the applicant will be notified that he is ineligible to apply for membership or privileges. The application will not be processed furthered and no right to due process or to a hearing will be triggered.

2.6.4 Credentials Committee Action

Once the Hospital medical staff office has a completed application, the verified application and its supporting materials shall be forwarded to the Medical Staff Credentials Committee. This committee shall review the application, supporting documentation, and such other information available to it that may be relevant to consideration of the applicant’s qualifications and it may conduct a personal interview. The committee or its chair may also request a subject matter expert on the medical staff review the application and provide input to the Credentials Committee.

After its review of the applicant’s credentials, the Credentials Committee shall submit a written recommendation to the MEC. This recommendation shall address the applicant’s request for medical staff membership and category, privileges, and any specific conditions relating to appointment and/or privileges. Minority views regarding any or all recommendations of the Credentials Committee may also be included.

2.6.5 Medical Executive Committee (MEC) Action

At its next meeting after receipt of the reports and recommendations of the Medical Staff Credentials Committee, the MEC shall review the applicant’s request for membership and/or privileges. The MEC may utilize additional sources of information, including personal interviews with the applicant, as it deems necessary to complete its evaluation.

After completing its review of the applicant’s qualifications the MEC shall transmit to the Hospital Board a written report and recommendation regarding appointment and/or privileges for the applicant, indicating whether the applicant’s requests should be accepted, accepted with modifications or qualifications, or rejected. Where appointment is recommended, the MEC shall also recommend staff category. Where the MEC recommends that the applicant’s requests for membership and/or privileges be rejected, modified, qualified, or otherwise restricted, the report of the MEC shall set forth reasons for such recommendation(s).

If an MEC recommendation is not unanimous, a minority report may be submitted to the Board.
2.6.6 **Effect of Medical Executive Committee Action (MEC)**

**Favorable Recommendation:** When the recommendation of the MEC is favorable to the applicant, the recommendation together with supporting documentation shall be forwarded to the Board.

**Deferred:** Any action by the MEC to defer a recommendation on the application in order to carry out further evaluation must be followed up within sixty (60) days with a recommendation to the Board.

**Adverse Executive Committee Recommendation:** When the MEC recommends denial or a restriction of membership or a requested privilege based on a determination of unprofessional conduct or inadequate clinical competence, the Medical Staff President or CEO shall inform the practitioner by special notice within ten (10) days. Physicians shall be entitled to the procedural rights following an adverse decision by the Board as provided in the Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws. The Hospital CEO and Hospital Board shall also be notified.

2.6.7 **Action of the Hospital Board**

Applicants for Consideration by the Full Board

At its next meeting after receipt of the reports and recommendations of the MEC regarding an application for membership and/or Privileges, the Hospital Board shall consider and act on such recommendations. If the Hospital Board decides to defer action on the application pending further consideration by the MEC, or if the Hospital Board does not accept the recommendation of the MEC, it shall refer the application back to the MEC for further consideration, subject to the requirement that a final recommendation be provided to the Hospital Board by the MEC within ninety (90) days. At the meeting next following the receipt of the second report of the MEC, the Hospital Board shall render its final decision regarding the application.

If the Board accepts a favorable MEC recommendation it shall act to grant the requested membership and/or Privileges.

If the recommendation of the MEC is adverse to the applicant, as defined under the Medical Staff Bylaws, the Hospital Board shall postpone its final decision on the applicant, pending the applicant’s decision to utilize or waive procedural rights. If an eligible applicant waives his right to a fair hearing and appellate review, the Board will then determine its final decision on the request for membership and/or Privileges. If an eligible applicant requests a fair hearing, the Board will make a determination on the applicant’s requests following a final recommendation from the MEC which takes into consideration the findings of the hearing panel. Where the applicant further requests an appellate review by the Board, its final determination will result from the decision made by the Board Appellate Review Committee.
When the Hospital Board decides to appoint an applicant to the Medical Staff, its decision and the notice of appointment shall include:

☐ the length of the appointment (not to exceed 24 months); ☐ the medical staff category to which the applicant is appointed; ☐ the privileges the applicant may exercise; and ☐ any special conditions attached to the appointment or exercise of privileges.

**Board Consideration of Expedited Applications:**

In those unusual and necessary situations where an applicant has been recommended for approval by the Medical Staff Executive Committee to the Board of Directors, and where approval is needed prior to the next meeting of the Board of Directors to facilitate timely provision of clinical services to meet patient and community needs. The President/CEO may conduct an expedited credentials review. Any such expedited approval by the President/CEO shall be specifically noted and presented to the Board of Directors for consideration and ratification when applicants present applications that raise no clear concerns from the MEC and/or members of the Board Executive Committee. In particular, the following criteria must be met in order to complete an expedited credentials review:

1. Applicant submits a completed application;
2. MEC makes a final positive recommendation and without limitation(s);
3. There are no current challenges or previously successful challenges to the applicant’s licensure or registration;
4. Applicant has never received an involuntary termination of medical staff membership at another organization;
5. Applicant has never received involuntary limitation, reduction, denial, or loss of clinical privileges; and
6. There is not an unusual pattern of, or extensive number of, professional liability actions.

This list is not exhaustive and the Hospital Board or the Board Executive Committee shall have the discretion to determine whether or not an application qualifies for expedited review.

After reviewing the recommendations of the MEC, a positive decision by the Executive Committee of the Board shall result in the status and/or privileges requested. If the decision by the Executive Committee of the Board is adverse the matter will be referred to the full Board for further evaluation at its next regularly scheduled meeting. The full Board shall consider and ratify all positive committee decisions at its next regularly scheduled meeting. If the Board does not ratify the positive recommendation of its Executive Committee, the application will be handled as in the same manner as an application that has not received expedited review.
2.6.8 **Conflict Resolution**

Whenever the Board’s proposed decision will be contrary to the recommendation of the MEC, the Board shall submit the matter for conflict resolution through the use of meetings and, if necessary, formation of a Joint Conference Committee as provided in Section 10.5 of Volume I of the Medical Staff Bylaws. Any such joint conference will be held as soon as practicable and the Board will postpone any final determination on an applicant until such conference is held.

2.6.9 **Notice of Final Decision**

Notice of the final action of the Hospital Board on an applicant shall be given to the Hospital CEO who will provide the applicant with either written notice of the Board’s grant of membership and/or privileges or special notice of any adverse action on the application in a timely manner.

The Hospital Board shall give notice of its final decision through the Hospital CEO to the Medical Staff President and the MEC.

2.6.10 **Time Periods for Processing**

Applications for medical staff appointment and/or privileges shall be considered timely and in good faith by all individuals and groups required by Medical Staff Bylaws and policies to act upon them and a shall be processed whenever possible within the time periods specified in this section. Any application that remains incomplete after six (6) months shall be considered voluntarily withdrawn.

Within sixty (60) days after the receipt of the completed and verified application, the Medical Staff Credentials Committee, through its chair, shall submit a written recommendation to the Medical Executive Committee.

Within sixty (60) days after receipt of recommendations from the Medical Staff Credentials Committee or its chair, the MEC shall submit a recommendation regarding appointment and/or privileges to the Hospital Board.

The Hospital Board will act on recommendations from the MEC at its next regularly scheduled meeting that shall occur within ninety (90) days.

The time periods in this section are guidelines and deviations will not entitle the applicant to any procedural due process rights.

2.7 **REAPPOINTMENT PROCESS**

2.7.1 **Application for Reappointment**

Reappointment will be for a period of two (2) years. At least one hundred and twenty (120) days prior to the expiration date of current appointment of membership and/or privileges, the Hospital shall provide each practitioner with an updated application form for reappointment and any required Hospital specific forms and documents for completion, which must be received prior to the reappointment application being acted upon. Each practitioner who desires reappointment shall, at least sixty (60) days prior to the expiration date of his current membership and/or privileges, must complete such forms and return them to the Hospital. Failure of the practitioner to return the completed form(s) within this time frame may, at the discretion of the Hospital, be considered a voluntary resignation of membership and clinical privileges effective at the end of the practitioner’s current term of membership and/or privileges.
2.7.2 **Content of Application**

The application for reappointment shall be in a prescribed form setting forth, without limitation, the following information:

a) Specific requests setting forth the category of staff membership to which the applicant seeks to be reappointed and the privileges for which the applicant wishes to be considered.

b) Continuing training, education, and experience that qualify the staff member for the privileges sought on reappointment. Continuing education must relate, at least in part, to the privileges requested and is provided to the Hospital upon request.

c) A statement that no health problems exist that could affect the applicant’s ability to perform the privileges requested.

d) The name and address of any other health care organization or practice setting where the staff member provided professional services during the preceding appointment period.

e) Any membership, awards, or other recognition conferred or granted by any professional health care societies, institutions or organizations.

f) Current, unrestricted State License, Drug Enforcement (DEA) and State Board of Pharmacy License, as applicable.

g) Information as to whether the applicant’s membership status and/or medical staff privileges have ever been voluntarily or involuntary revoked, suspended, reduced, subjected to restrictions or limitation if not applicable to all other practitioners in the same medical staff category, or not renewed at any other Hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

   1) staff membership status or clinical privileges at any other Hospital or health care institutions; 2) membership/fellowship in a local, state or national professional organization; 3) specialty board certification;
4) privileges in any health plan which carries out credentialing of health plan practitioners; 5) licensure to practice any profession in any jurisdiction; or 6) Drug Enforcement (DEA) registration;

If any such actions were ever taken or if any such actions are pending, the particulars shall be included by the applicant as part of the application for reappointment.

h) National Practitioner Data Bank (NPDB) information, which will also be checked during reappointment/renewal of privileges and whenever new privileges are requested.

i) Information as to whether the applicant has ever been prosecuted for, convicted of or pled no contest to a felony and, if so, the particulars of any such convictions.

j) Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

k) Evidence of continuous malpractice insurance coverage in an amount that may be determined from time to time by action of the Board.

l) A list of all malpractice complaints filed against the practitioner and the particulars regarding any adverse malpractice decisions or settlements.

m) Such other specific information about the staff member’s professional ethics, qualifications, and ability that may bear on his ability to provide medical or surgical care in the Hospital.

n) Information regarding whether the applicant has been convicted of any type of insurance fraud, been found guilty under the False Claims Act, or is on the OIG Excluded Provider list for Medicare and Medicaid.

2.7.3 Completion and Verification of Information

The information provided on each application for reappointment and all other supporting materials and documentation, including information regarding the staff member’s professional activities, performance and conduct in the Hospital and query reports from the National Practitioner Data Bank shall be collected and verified. The applicant shall have the burden of producing adequate information for a proper evaluation of his qualifications and of resolving any questions regarding such qualifications. When collection and verification has been completed and the Hospital has determined that the application is complete, it shall transmit the application and all supporting material to the Credentials Committee.
2.7.4 Credentials Committee Action

The Medical Staff Credentials Committee shall review each application and all other relevant information available to it. The Credentials Committee may choose to interview the applicant prior to rendering a recommendation any it may request input from any relevant subject matter expert. The Credentials Committee shall make a report to the Medical Executive Committee regarding its recommendations on the application for reappointment. The report of the Credentials Committee shall be accompanied by all relevant documentation, including the application, and supporting information.

2.7.5 Medical Executive Committee Action

The Executive Committee shall review each application for reappointment and all other relevant information available to it. The MEC may choose to interview the applicant prior to rendering a recommendation. The MEC shall make a report to the Hospital Board regarding its recommendations on the application for reappointment. The report of the MEC shall contain the same specific types of recommendations contained in the report of the Credentials Committee. The report of the MEC shall be accompanied by all relevant documentation, including the application, supporting information, and the report of the Credentials Committee.

2.7.6 Final Processing and Board Action

Following the report of the Executive Committee to the Hospital Board, the procedure provided in this Credentials Procedure Policy relating to initial applications shall be followed and the Hospital Board shall render a decision prior to the expiration date of the applicant’s appointment. Where the Board disagrees with the recommendation of the MEC, the matter will be addressed through the conflict resolution process as described in Section X in Volume I of the Medical Staff Bylaws.

2.7.7 Basis for Recommendation

Each recommendation concerning the reappointment of a practitioner’s membership and/or privileges shall be based upon review not only of those matters set forth in the Medical Staff Bylaws and policies pertaining to such practitioner, but also on any other information bearing on the ability and willingness of the practitioner to contribute to the rendering of quality health care within the Hospital and to contribute to the mission of the Hospital.

2.8 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS AND/OR PRIVILEGES

A medical staff member may, either in connection with reappointment or at any other time, request modification of his staff category, or clinical privileges by submitting a written application to the Hospital in such form as may be prescribed by the MEC and the Hospital Board. Such staff member shall have the burden of justifying such modification(s). Such application shall be processed in substantially the same manner as applications for reappointment to medical staff membership and/or privileges.
2.9 EFFECTIVE DATE OF REAPPOINTMENT/MODIFICATIONS OF APPOINTMENTS AND/OR STAFF PRIVILEGES

Reappointments approved by the Hospital Board, including privileges awarded in connection with such reappointments, modifications to category of staff membership, and/or privileges, shall take effect on the date such modifications are approved by the Hospital Board.

ARTICLE III

DETERMINATION OF PRIVILEGES

3.1 EXERCISE OF PRIVILEGES

Practitioners providing clinical services at the Hospital shall be entitled to exercise only those privileges specifically granted to them by the Hospital Board, or temporary, emergency or disaster privileges as described below in this Credentialing Procedure Policy.

3.2 DELINEATION OF PRIVILEGES IN GENERAL

3.2.1 Requests

Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant. Practitioners who are ineligible for medical staff membership may apply for privileges by requesting an application form from the Hospital. A request by a practitioner for privileges or the modification of privileges must be supported by all requested documentation regarding appropriate licensure, training and evidence of current competence. Privilege requests will not be processed where the applicant does not meet the eligibility requirements to be granted the privilege at St. Mary’s Hospital and Medical Center.

3.2.2 Basis for Determinations of Privileges

Privileges shall be determined on the basis of the practitioner’s prior and continuing education, training, experience, utilization patterns and demonstrated current competence, including observed professional performance and documented results of practitioner-specific performance improvement activities. Information concerning professional performance obtained from other sources will be considered when available, especially from other institutions and health care settings where a practitioner exercises privileges. It is the burden of the practitioner applying for privileges to provide all information requested by the Medical Staff and Board as they determine necessary to evaluate the request.
Residents or fellows in training in an approved ACGME program and acting under the auspices of that program will not be required to request specific privileges. They must carry out any clinical care in accordance with the written educational protocols developed by the Hospital VPMA, or designee, and their training program. These protocols must delineate the roles, responsibilities, and scope of clinical activities applicable to such trainees. They must also describe the requirements for oversight of trainees, the types of orders they may write, and when such orders must be countersigned and by whom. The protocols will describe how trainees’ level of responsibility and scope of practice may expand over time and how this information will be transmitted to staff and personnel working in the Hospital. These protocols must be periodically reviewed and approved by the MEC. In addition, training programs will periodically communicate with the MEC regarding the performance of its trainees and alert it to any performance concerns or matters that may threaten patient safety. The training program must work with the MEC to assure that all supervising practitioners hold privileges commensurate with their oversight activities.

3.2.3 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article II of this Credentials Procedure Policy. Requests for privileges will not be processed where the Board has made a determination that the Hospital will not support or authorize the exercise of a particular privilege for any practitioner at the Hospital; where the privilege requested is covered by an exclusive contract granted by the Hospital Board and the requesting practitioner is not a party to the contract or a provider under the contract; or where the requesting practitioner does not meet the eligibility requirements to request or exercise a privilege as described in the Hospital’s delineation of privileges documents. Physicians requesting Privileges must satisfy all the requirements of medical staff membership and agree to the responsibilities of membership. However, those granted Privileges only will not be subject to medical staff dues.

3.2.4 New Technology or Cross-Specialty Privileges

In the event a practitioner requests a privilege for which the Hospital has not adopted criteria (e.g. for a new technology, procedure, modality or multi/crossspecialty privilege), the request may be tabled for a reasonable period of time, usually not in excess of ninety calendar days. During this time the MEC and Board will review the community, patient, and Hospital need for the privilege and determine if the institution can make available the necessary resources to adequately support the exercise of that privilege. Hospital management will resolve any non–exclusive or exclusive contract issues as appropriate to avoid violating the contract provisions. The Medical Staff Credentials Committee will research appropriate eligibility criteria for the safe and effective exercise of the requested privilege and establish, with input of the MEC and approval by the Board, the necessary education, training, experience and evidence of current competence that will be required to request and be granted the privilege. Once these steps are taken, a request for the privilege will be evaluated.
The procedure to be used in determining if a procedure, modality of care or treatment requires new/updated/different competency criteria prior to being eligible to request and be granted the privilege by the Board is as follows:

When the chair or two (2) or more members of the Credentials Committee determine that two (2) or more of the following criteria significantly differentiate the new privilege from a currently approved privilege, new/additional competency criteria will be developed by the Credentials Committee: skill, knowledge, technique, equipment, judgment or ability to manage complications the procedure, modality of care or treatment.

3.3 CONFIRMATION OF COMPETENCY TO HOLD ASSIGNED PRIVILEGES

The Medical Staff will confirm the competence of all Practitioners newly granted privileges at SMHMC. This will occur following the practitioner’s initial appointment of privileges and subsequently at any time a new privilege is requested for addition to the practitioner’s then current privileges. This activity will occur in conformance with a policy on Focused Professional Practice Evaluation (FPPE) adopted by the MEC. This policy will determine the manner and duration of the evaluation of the practitioner’s exercise of privileges and the available monitoring modalities that may be used. As a result of this initial FPPE, the Credentials Committee may recommend to the MEC and Board modifications in the privileges granted upon initial appointment.

The medical staff participates in ongoing professional practice evaluation (OPPE) to identify practitioner performance concerns and trends that impact the safety and quality of patient care. Information from the OPPE process will be used by leaders to determine if existing privileges are maintained, revised or revoked prior to or at the time of reappointment. The OPPE is part of the medical staff’s evaluation, measurement, and improvement of practitioner’s current clinical competency. In addition, each practitioner may be subject to a focused professional practice evaluation when issues affecting the provision of safe, high quality patient care are identified.

3.4 TEMPORARY CLINICAL PRIVILEGES

3.4.1 Circumstances

Temporary privileges may be granted by the Hospital CEO to a practitioner who meets one of the following circumstances and the minimum criteria as defined below:

a) Important Patient Care Need

Temporary privileges may be granted on a case-by-case basis when an important patient care need or service mandates an immediate authorization to practice for a limited time—up to one hundred and twenty days (120) days.

In special circumstances upon receipt of a written request, an appropriately licensed practitioner of documented competence, who is not an applicant for membership or privileges, may be granted temporary privileges for the care of one or more specific patients.
The following documentation is required for temporary privileges:

- Unrestricted Colorado License
- Unrestricted Federal DEA, if appropriate
- Current valid professional liability insurance coverage in a certificate form
- and in amounts satisfactory to the Hospital
- Current standing from primary practicing facility, if applicable
- National Practitioner Data Bank report (processed by the Medical Staff Office)
- A verbal or written reference which establishes current competency.

b) Pendency of a New Application for Medical Staff Membership and/or Privileges:

Temporary clinical privileges may be granted to applicants seeking new medical staff membership and privileges, provided the application is complete, and the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. All required verifications and processes as outlined in Article II of this Credentials Procedure Policy must be completed and the application is awaiting review and recommendation of the Medical Executive Committee. Utilizing temporary privileges, a practitioner may only attend patients for a period not to exceed one hundred and twenty (120) days.

3.4.2 Conditions

Temporary privileges shall be granted by the Hospital CEO (or designee) acting on behalf of the Board and based on a recommendation of the Medical Staff President (or designee). Before temporary privileges are granted, the practitioner must first acknowledge in writing that he has been given access to and read copies of the Medical Staff Bylaws and all other medical staff and Hospital policies relevant to his performance of temporary privileges, and that he agrees to be bound by them.

3.4.3 Termination

On discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner’s professional qualifications or ability to exercise any or all of the temporary privileges granted, the Medical Staff President or Hospital CEO, may terminate any or all of such practitioner’s temporary privileges. Where the life or well being of a patient is determined to be endangered by continued treatment by a practitioner exercising temporary privileges, the termination may be effected by any person entitled to impose Precautionary Suspensions under the Medical Staff Bylaws. In the event of such termination, the patients of such practitioner then in the Hospital shall be assigned to another practitioner by the Medical Staff President or designee. Where feasible, the wishes of the patient shall be considered in choosing a substitute practitioner.
3.4.4 **Procedural Rights**

A practitioner shall not be entitled to procedural rights because of the denial of any request for temporary privileges, or because of any termination or suspension of temporary privileges, whether in whole or in part, unless based on a determination of demonstrated incompetence or unprofessional conduct.

3.5 **EMERGENCY PRIVILEGES**

In case of an emergency, any medical staff member or privileged practitioner attending a patient shall be expected and permitted to do everything in his power and to the degree permitted by his license, to save the life of the patient or prevent significant and disabling morbidity regardless of the member’s medical staff status or granted privileges. This duty shall be subject to the practitioner’s concurrent duty to take into account or abide by a patient’s directive under the Colorado law to withhold or withdraw life-sustaining procedures, or to take into account and abide by the requirements of sound medical practice. For purposes of this section, an emergency is defined as a condition or set of circumstances in which any delay in administering treatment would increase the danger to the patient’s life or the danger of serious harm. When such an emergency situation no longer exists, the patient shall be assigned to an appropriate member of the medical staff who holds privileges appropriate to address the patient’s medical conditions.

3.6 **DISASTER PRIVILEGES**

3.6.1 **Authority**

The authority to implement disaster privileges is at the direction of the Hospital Command Center, in consultation with the medical staff leadership, in the event the Emergency Management Plan is activated and the Hospital is unable to handle immediate patient care needs. One of the following individuals may grant disaster privileges once appropriate identification is obtained from a physician who has offered to volunteer during a disaster:

- a) CEO or designee
- b) Medical Staff President or any elected officer of the medical staff
- c) Medical Staff Credentials Chair

3.6.2 **Eligible Physician**

Disaster privileges may be granted only to physicians, who hold a license in the State of Colorado to practice medicine and who volunteer their services but do not possess medical staff privileges at St. Mary’s Hospital and Medical Center.

Before a volunteer physician is considered eligible to function, the hospital obtains his or her valid government-issued photo identification (e.g., driver’s license, passport) and at least one of the following:

1. A current picture identification card from a health care organization that clearly identifies professional designation
2. A current license to practice
3. Primary source verification of licensure
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
5. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
6. Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer physicians’ ability to act as a licensed independent practitioner during a disaster
a. Primary source verification of licensure will begin as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer physician presents to the Hospital. Primary source verification applies only to volunteer physicians who provided care, treatment and services while under disaster privileges.

b. In extraordinary circumstances where primary source verification cannot be completed within seventy-two (72) hours, it will be completed as soon as possible and the reasons for the delay documented.

3.6.3 **Scope of Privileges**

Volunteering physicians shall be paired with and supervised by a currently credentialed medical staff member. The credentialed medical staff member will oversee the performance of the volunteer physician through direct observation, mentoring, medical record review, etc. An approved form of identification must be worn at all times while volunteering at the Hospital. Scope of privileges for the volunteering physician shall be consistent with privileges typically practiced by a practitioner in the relevant specialty and as determined by the onsite supervising physician. Within seventy-two (72) hours of disaster privileges being granted the medical staff leadership will make a determination of the professional practice of the volunteer physicians and the need for continuation of disaster privileges.

3.6.4 **Termination of Privileges**

Disaster privileges will be for the duration of the emergency situation. Privileges will automatically be canceled when it is determined by the Hospital that an emergency situation no longer exists. In the event that any information received through the verification process or the professional practice review indicates adverse information suggesting the person is not capable of rendering services in an emergency such privileges shall be immediately terminated.
3.7 TELEMEDICINE PRIVILEGES

a) Applicants seeking clinical privileges to perform telemedicine services may, but need not, be processed pursuant to the complete appointment/reappointment and privileging process described in Article II of this Manual. As an alternative to the privileging process described in Article II, the MEC may make recommendations to the Hospital Board regarding applicants who intend to provide telemedicine services under a written agreement(s) between the Hospital and a distant-site hospital or entity by relying on the credentialing and privileging decision of the distant-site hospital or entity with whom the Hospital has agreement(s) for telemedicine services.

b) Applicants based at distant-site hospitals or entities who intend to provide telemedicine services under a written agreement(s) with the Hospital may apply for telemedicine clinical privileges provided each applicant meets the basic qualifications set forth in Article II above and by submission of the same application or application with equivalent content as specified in this manual. All determinations regarding equivalent content will be made by the MEC and/or Hospital Board.

c) Upon confirmation by the Medical Staff Office that an applicant's request for telemedicine privileges complies with the terms of the written agreement(s) between the Hospital and the distant-site hospital or entity, including clinical privileges criteria adopted by the Medical Staff, the MEC may rely upon the credentialing and privileging decisions made by a distant-site hospital or telemedicine entity when making its recommendation to the Hospital Board for clinical privileges provided the agreement(s) between the Hospital and distant-site hospital or entity ensures the following:

1) The distant-site hospital is a Medicare participating hospital or the distant-site telemedicine entity provides written assurances to the Hospital that its credentialing and privileging process and standards meet the Medicare Conditions of Participation for Hospitals;

2) The Practitioner is privileged at the distant-site hospital or distant-site telemedicine entity and a current list of equivalent privileges is provided;

3) The distant-site Practitioner holds a current license issued or recognized by the State of Colorado;

4) That upon being granted clinical privileges, the Hospital provides the distant-site hospital or entity evidence of an internal review at the Hospital of the Practitioner’s clinical performance for use in the Practitioner’s periodic appraisal and, at a minimum, the information must include all adverse events resulting from the telemedicine services provided by the distant-site Practitioner as well as any registered complaints.

d) If the Hospital has not entered into a written agreement(s) for telemedicine services with a distant-site hospital or entity but has a pressing clinical need for telemedicine services and a distant-site Practitioner can supply such services via a telemedicine link, the applicable Department Chair and Hospital administrator may evaluate the use of temporary clinical privileges for a distant-site Practitioner as described above. In such cases, the distant-site Practitioner must be credentialed and privileged to provide telemedicine services in accordance with the Hospital’s standards and procedures applicable to the approved telemedicine services.
ARTICLE IV

PRACTITIONERS PROVIDING CONTRACTED SERVICES

4.1 EXCLUSIVE AGREEMENTS

The Hospital Board may from time to time determine that specified Hospital clinical services will be provided on an exclusive basis pursuant to a contract or letters of agreement between the Hospital and specific qualified practitioners. Privileges covered by such exclusive agreements will be available only to practitioners who are specified under the terms of such agreements. Applications for initial appointment to provide services or requesting privileges that are covered under the exclusive arrangement will not be eligible for consideration and processing unless submitted in accordance with such arrangements. Practitioners who have previously been granted privileges that become subject to an exclusive arrangement made by the Hospital will not be able to exercise those privileges unless they become a party to the agreement. Any practitioner who will provide clinical services pursuant to an exclusive agreement issued by the Hospital will be required to meet the same qualifications and undergo the same evaluation and approval process for privileges as any other applicant. However, the exclusive contract may require such practitioner to meet higher qualifications for privileges than those established for applicants who are not subject to the exclusive agreement.
4.2 **TERMINATION OF CONTRACTED ARRANGEMENTS**

The effect of expiration or other termination of a contract for employment or professional services between the Hospital and a practitioner upon that practitioner’s staff appointment and privileges will be governed solely by the terms of the practitioner’s contract with the Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner’s staff appointment status or privileges. Where medical staff membership or privileges are terminated under the terms of such contracts the practitioner will not have recourse to the due process provisions described in the Medical Staff Investigation, Corrective Action and Fair Hearing Procedures.