Medical Staff

CREDENTIALING MANUAL

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SECTION 1. DEFINITIONS

1.1 For purposes of this Manual, certain terms are defined within the Medical Staff Bylaws.

SECTION 2. OVERVIEW

2.1 Purpose of Credentialing Manual

2.1.1 The purpose of the credentialing manual of the Hospital is to set policies which will assure, to the extent possible, that patients are cared for at the Hospital by qualified and competent individuals, that all patients, employees and practitioners at the Hospital are treated with respect and dignity at all times and that each practitioner who is granted membership to the Medical Staff of Boulder (Medical Staff) and/or clinical privileges at the Hospital will make a significant contribution to achieving the mission of the Hospital.

2.2 Credentialing Policy

2.2.1 It is the policy of the Governing Board of Hospital to grant membership to the Medical Staff and/or clinical privileges at the Hospital only to practitioners who can demonstrate at the time of application that they possess the requisite medical education, training, and experience, meet or exceed all qualifications for Membership and/or clinical privileges, and satisfy the criteria for the specific clinical privileges requested.

2.2.2 Waivers - There may be occasions when a practitioner/Advanced Practice AHP fails to meet the minimum clinical activity requirement, education/training requirement or other standard for a specific privilege or group of privileges. The relevant Department Chair and/or the Credentials Committee may recommend to the Medical Executive Committee and the Board that the requirement in question be waived – and document the specific rationale for why the requirement is recommended to be waived. The individual who is requesting a waiver is responsible for demonstrating that his or her education, training, experience and competence are equivalent to or exceed the requirements that are requested to be waived. Waiving of requirements should be an unusual occurrence, but it is acknowledged that there may be times when patient safety will not be compromised by alternative methods of assuring competency. Waiving of requirements for privileges is always a Board decision. The Board may grant waivers in exceptional cases after considering the findings of the Medical Executive Committee, the specific qualifications of the individual in question, the quality profile of the individual and his or her performance record in the medical center. Ultimately, what is in the best interests of patient care and the community served by the medical center is the primary consideration.

No individual is entitled to a waiver or to any hearing procedures in the event the Board determines not to grant a waiver. The individual has not received a denial, but is simply ineligible to apply. In the event the Board grants a waiver to any particular individual, that waiver shall not constitute a precedent for any other practitioner or group or practitioners. Each individual request for a waiver will be evaluated on its own merits.

2.3 Responsibility for Professional Review and Credentialing Activities[1]

2.3.1 It is the responsibility of the Medical Staff to perform professional review and credentialing activities as delegated by the Governing Board in accordance with the bylaws and credentialing policies of the Hospital and the Medical Staff.

2.3.2 The Medical Staff, through its leadership and its various committees, shall assist the Governing Board in determining the qualifications of practitioners for membership and clinical privileges and, subject to the final action of the Governing Board, shall conduct professional review activities and recommend professional review actions.

2.3.3 It is the responsibility of the Governing Board to make the final determination to grant or deny a request for membership and/or clinical privileges and to take final action in all professional review activities.

2.3.4 It is the responsibility of the Medical Staff Department and, as the designee of the Chief Executive Officer of the Hospital, the Director of the Medical Staff Department, to assist the Medical Staff and the Governing Board in professional review and credentialing activities by processing applications for membership and/or clinical privileges, providing information to the Medical Staff and Governing Board, and performing other functions set forth in the credentialing policies of the Hospital and the Medical Staff.

2.3.5 In participating in any credentialing or professional review activity, the Governing Board, Medical Staff, and any committees thereof are acting as professional review bodies and/or professional review committees. Individuals who participate in any professional review activities or provide information to a professional review body or committee, including without limitation, members of the Governing Board, Medical Staff and the Medical Staff Department, shall be entitled to immunity from liability to the greatest extent permitted under state and federal laws.

SECTION 3. APPLICATION POLICY

3.1 It is the policy of the Hospital to consider applications for appointment to the Medical Staff and/or clinical privileges only to practitioners who meet the eligibility criteria as outlined in Section IV of this Credentialing Manual.

3.2 A practitioner is not eligible to apply for membership or clinical privileges if the clinical specialty area in which the practitioner practices has been closed by the Governing Board or is under exclusive contract with the Hospital, as determined by the Governing Board.

SECTION 4. ELIGIBILITY CRITERIA

4.1 All requests for applications for appointment to the Medical Staff and/or for clinical privileges will be forwarded to the Medical Staff Department. Upon receipt of a request, the Medical Staff Department will provide the applicant with an application packet, which delineates the eligibility criteria for application. The applicant must meet the minimum criteria, as stated below, for acceptance of the application.

4.1.1 They are an MD, DO, DDS, DPM, PhD/PsyD or an appropriate Allied Health Professional.

[1] The terms "professional review activity," "professional review action," "professional review body" and "professional review committee" shall have the meanings assigned to them in the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101, *et seq.* and the Colorado Professional Review Statute, Colo. Rev. Stat. §§ 12-36.5-101, *et seq.*

4.1.2 They have, within the last twelve months, been engaged in active clinical practice or engaged in medical related activities, including academics.

4.1.3 They have actively practiced in an accredited hospital at least two of the past five years. Three months of recent experience in a full-time clinical residency will be considered equivalent.

4.1.4 They have established or plan to establish an office and residence within sixty miles of the hospital or have specific set arrangements made with a member of the Medical Staff of Boulder for coverage, if applicable.

4.1.5 They are licensed to practice or have applied to be licensed to practice in this state, if applicable.

4.1.6 They currently have professional liability insurance or have applied for professional liability insurance in the amount specified by the Governing Board.

4.1.7 They have successfully completed an approved residency and/or training program. An exception to this criterion may be made, as noted on individual CORE privilege forms, for practitioners who have documented training and experience comparable to residency or applicable training. (See Board Policy)

4.1.8 They are currently board certified by a recognized ABMS/AOA/AAUCM member board or must attain ABMS/AOA/AAUCM member board certification within the timeframe as specified by the member board post training. [ABMS-American Board of Medical Specialties; AOA-American Osteopathic Association; AAUCM-American Academy of Urgent Care Medicine]. (MEC 4/09, 2/12)

4.1.9 Their privileges or right to practice at any other hospital or healthcare facility have not been revoked.[2]

4.1.10 Their license to practice has not been revoked in any state or is not at the time of application under suspension.[2]

4.1.11 Their privileges at another hospital or health care entity are not at the time of application under suspension, other than an administrative suspension for grounds unrelated to the practitioner's competence or professional conduct.[2]

4.1.12 They have not been excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or, convicted of a criminal offense related to the provision of health care.

4.2 Upon receipt of the application packet the Medical Staff Department will review the application and will determine if each of the above criteria for membership and privileges are met. In the event each of the criteria for membership and privileges are not met, the potential applicant will be notified. The determination that an applicant is not eligible for membership or privileges is an administrative determination and shall not entitle the applicant to any of the procedures under the Fair Hearing Plan.

SECTION 5. MEDICAL STAFF MEMBERSHIP AS A PRIVILEGE

5.1 Membership on the Medical Staff and the ability to exercise clinical privileges at the Hospital are privileges available only to those practitioners who can demonstrate at the time of application

[2] *A practitioner whose privileges or license has been revoked may be eligible for membership and/or privileges if the practitioner demonstrates that his privileges or license was subsequently reinstated by the same entity that revoked the license or privilege. Paragraphs I, J, K and L shall not apply to a revocation or suspension of a practitioner's license or privileges which occurred prior to November 26, 1996, provided that as of that date, the practitioner is an AHP or member in good standing, as that term is defined in paragraph H above.

their qualifications for such membership and/or clinical privileges. No practitioner shall be automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges for any reason. Nor shall any practitioner be automatically entitled to appointment, reappointment or particular privileges merely because he had, or presently has, membership or those particular privileges at the Hospital or for any other reason.

SECTION 6. QUALIFICATIONS FOR MEMBERSHIP AND/OR PRIVILEGES

6.1 It is the policy of the Hospital and Medical Staff to offer membership and/or clinical privileges only to those practitioners who demonstrate that they will make a significant contribution to the mission of the Hospital.

6.2 Practitioners shall be considered for membership and/or clinical privileges only if they meet the following professional qualifications and standards:

- 6.2.1 Practitioners must be currently licensed to practice in the State of Colorado (if applicable) and must be able to present current documentation of the following:
- 6.2.2 requisite professional education and training, and/or background;
- 6.2.3 demonstrated ability and judgment;
- 6.2.4 relevant experience by clinical results;
- 6.2.5 current competence to practice their profession and perform all requested privileges;
- 6.2.6 freedom from any significant physical, emotional or behavioral impairment, which prevents them from meeting the other qualifications for membership and/or clinical privileges;
- 6.2.7 an ability to communicate verbally and in writing in the English language;
- 6.2.8 acceptable professional claims history;
- 6.2.9 adherence to the lawful ethics of their profession;
- 6.2.10 adherence to the highest level of honesty and integrity;
- 6.2.11 an ability to work cooperatively with others in the Hospital setting and with professional peers in the Community in a consistently cordial and productive manner;
- 6.2.12 an ability to appropriately utilize available resources;
- 6.2.13 that they do not use drugs or alcohol or any other similar substance to an extent that would or would be likely to prevent or alter their ability to practice their profession and perform the requested clinical privileges in a competent manner or any mental or organic conditions which pose a risk to patients;
- 6.2.14 and a willingness and ability to participate in and properly discharge other applicable Medical Staff and/or AHP responsibilities;
- 6.2.15 an ability to sufficiently provide continuous quality care to their patients to reasonably assure the Medical Staff and the Governing Board of the Hospital that any patient treated by them in the Hospital will receive care of a quality that is consistent with the highest standards and aims of the Governing Board and Medical Staff; and
- 6.2.16 proof of health screening/immunization/drug testing as required by Medical Staff or Board policy. (8/2012)

6.3 Practitioners must meet the malpractice insurance coverage requirement of $1/$3M or in such greater amount as required by the practitioner's insurance carrier for the performance of special procedures.

6.4 An Active or Associate practitioner's office or residence must be located within sixty (60) miles of the Hospital unless otherwise provided in the Rules and Regulations of the applicable Department, in which case, the practitioner must demonstrate that he is able to provide continuous care to patients at the Hospital.

6.5 It shall be the burden of the applicant to demonstrate to the satisfaction of the Governing Board that at the time of application the applicant meets all the qualifications for membership and/or clinical privileges and to resolve all doubts or concerns regarding his qualifications for membership and/or clinical privileges. An applicant shall not be entitled to receive privileges for the purpose of demonstrating that the applicant meets the qualifications for membership or clinical privileges.

SECTION 7. BASIC OBLIGATIONS OF MEMBERSHIP

7.1 Each member of the Medical Staff, regardless of his assigned staff category shall:

- 7.1.1 Provide patients with quality care at the generally recognized professional level of quality and efficiency in the community.
- 7.1.2 Abide by all state and federal laws regulating health care providers, as well as by the Medical Staff bylaws, rules and regulations and all other lawful standards, policies and rules of the Medical Staff, of the Hospital and of the Department(s) wherein he exercises clinical privileges.
- 7.1.3 Discharge assigned Medical Staff, Department, Committee and Hospital functions, including, but not limited to, quality assurance, peer and professional review, patient care monitoring, utilization review, case management and other coverage responsibilities, including, but not limited to, emergency services and backup functions, acceptance of consultations and supervision of applicants for clinical or practice privileges.
- 7.1.4 Cooperate with and participate in Medical Staff committees and other committees of the Hospital as requested, including, but not limited to, strategic planning of services and service on Medical Staff Department Sections.
- 7.1.5 Retain responsibility for the continuous care and supervision of each patient for whom he is providing services in the Hospital or arrange for a suitable alternate to assure such continuous care and supervision.
- 7.1.6 Maintain all other qualifications for membership set forth in this Section IV of this Credentialing Manual, "Qualifications for Membership".
- 7.1.7 Submit to such physical and/or mental examination or provide verification of health status as may be required by the Medical Executive Committee to assure the Medical Staff of the practitioner's ability to fully meet his responsibilities as a Medical Staff member and/or to perform the requested clinical privileges.
- 7.1.8 Maintain the required level of professional liability insurance coverage and report to the Medical Staff Department any change in professional liability insurance coverage within thirty (30) days from said change.
- 7.1.9 Pay dues unless a special exception with regard to payment of dues has been recommended and approved by the Medical Executive Committee or unless otherwise provided in Medical Staff or Hospital policies.
- 7.1.10 Report to the Medical Staff Department any involvement in a professional liability action involving a complaint, judgment or settlement within thirty (30) days from the date of said final judgment or settlement. If a practitioner is involved in a legal case or has a

malpractice claim pending at the time of his/her reappointment, verbiage will be included in their approval letter from the CEO indicating they need to contact the Medical Staff Department when the case has been concluded to inform them of the outcome.

7.1.11 Report to the Medical Staff Department any action taken affecting licensure, certification, registration or DEA certification, including, but not limited to, voluntary or involuntary relinquishment of the same within thirty (30) days of said action.

7.1.12 Refrain from any division of professional fees in violation of state or federal law.

7.1.13 Prepare and complete in a timely fashion accurate medical and other required records for all patients he admits or provides care to at the Hospital.

7.1.14 Abide by the lawful ethical principles of his profession.

7.1.15 Aid in educational programs when so assigned.

7.1.16 Assist the Hospital in fulfilling its uncompensated or partially compensated patient care obligations.

7.1.17 Utilize hospital resources appropriately.

7.1.18 Treat all individuals at or associated with the Hospital courteously, respectfully and with dignity at all times.

SECTION 8. INITIAL APPOINTMENT

8.1 Application for Medical Staff appointment and/or clinical privileges is to be submitted by the applicant. The application should be typed or legibly written on the form designated by the Credentials Committee and approved by the Governing Board. Prior to the application being submitted, the applicant will be provided with a copy of or have access to a copy of the Hospital Corporate Bylaws, the Medical Staff Bylaws, accompanying manuals, applicable privilege delineation forms (threshold criteria), and the rules and regulations of the Medical Staff and its departments.

8.2 The applicant must sign the application and in so doing:

8.2.1 Signifies his willingness to appear for interviews, if requested.

8.2.2 Authorizes Hospital representatives to consult with others who have been associated with him and/or who have information bearing on his current clinical competence and qualifications.

8.2.3 Consents to Hospital representatives[3] inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he requests, of his physical and mental health status and of his professional and ethical qualifications.

8.2.4 Releases from any liability all Hospital representatives for their acts performed in good faith and without malice in connection with evaluation of his qualifications for membership and clinical privileges.

8.2.5 Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information to Hospital representatives in

[3] The term "hospital representatives" includes the Governing Board, its Chairman and committees; the Chief Executive Officer or his designee, employees of the Hospital, the Hospital and the Medical Staff organization and all Medical Staff members, clinical units and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his application and any consultants retained by the Hospital or Medical Staff to assist in professional review and credentialing activities.

good faith and without malice concerning his competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff membership and clinical privileges.

8.2.6 Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning him, and releases Hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

8.2.7 Indicates by signature that he has received and read the bylaws, rules and regulations of the Medical Staff and agrees to abide by these documents as they currently exist and as subsequently amended for the purposes of appointment to the Medical Staff of Boulder Community Health.

8.2.8 Agrees to participate in the Organized Health Care Arrangement ("OHCA") established by Boulder Community Health and the Medical Staff of Boulder.

SECTION 9. PROCESSING APPLICATIONS FOR STAFF APPOINTMENT

9.1 Upon request, eligible applicants will be given an application for Medical Staff appointment and/or clinical privileges and other related documentation as outlined in this Manual.

9.2 The applicant shall have the burden of producing current, accurate and sufficient information for the Credentials Committee and subsequent professional reviewing bodies or committees to properly evaluate his competence, character, ethics, and other qualifications for membership and/or clinical privileges and shall have the burden of resolving any doubts about his qualifications for membership and/or clinical privileges. The applicant shall verify that the information is accurate and shall have the burden of updating the information, if necessary, to keep it current.

9.3 The following documentation is necessary to complete an application. It is the applicant's responsibility to provide:

9.3.1 A typed or legibly written (completed), signed application form and request for privileges which identifies the staff category for which the applicant wishes to be considered.

9.3.2 A copy of current controlled substances registration certificate (DEA), registered with local address (if applicable).

9.3.3 A copy of current professional liability insurance policy for the amount specified by the Governing Board.

9.3.4 <u>Peer References.</u> The application must include the names of three (3) medical or health care professionals, not related to the applicant, who have personal knowledge of the applicant's qualifications and who will provide specific written comments on these matters. Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice. The named individuals must have acquired the requisite knowledge through recent observation (within the past two years) of the applicant's professional performance and clinical competence over a reasonable period of time. Where any of the references are less than favorable or express some concerns further explanations or references will be required. Two of the three professional references may be from

practice associates. At least one reference in the same specialty as the applicant is preferred.

9.3.5 Complete names and addresses of all institutional affiliations since completion of post-graduate education. This includes all hospitals, corporations, military assignments or government agencies. Affiliations will routinely be verified for the last ten years and may include verification of affiliations exceeding that timeframe as deemed necessary.

9.3.6 Complete names and addresses and telephone numbers of all insurance companies that have provided malpractice coverage for the applicant over the past five years.

9.3.7 Complete information concerning any professional liability claims, complaints, or causes of action that have been lodged against the applicant which are pending or if any judgments or settlements have been made against the applicant. This shall include complete information and full explanation of the court in which the suit was filed, the caption and docket number of the case, the complete name and address of the Plaintiff and Defendant's attorneys, the status or outcome of such matters and all other relevant details.

9.3.8 Complete information regarding medical licenses which have been held in the past or currently, to include the state, date issued, license number and status of each (current or expired). Complete information regarding whether a medical license to practice is pending in any jurisdiction.

9.3.9 Information as to whether any action, including any investigation, has ever been undertaken, and whether it is still pending or completed with regard to: the denial, revocation, suspension, reduction, restriction, limitation, probation, non-renewal or voluntary or involuntary surrender (by resignation or expiration) of the applicant's membership status and/or clinical privileges or prerogatives at any other hospital or institution within or outside the state; whether his membership in local, state, national or international professional societies or his license or certification to practice his profession in any jurisdiction has ever been denied, suspended, terminated, restricted or if any such action is pending; whether federal or state narcotic license or specialty board certification and/or professional school student or faculty position or membership has ever been denied, suspended or, revoked or restricted or if any such action is pending.

9.3.10 Completed delineation of clinical privilege forms and detailed information and supporting documentation, as per credentialing criteria concerning the applicant's professional qualifications, training and experience to perform the requested privileges.

9.3.11 Copies of certificates from completed continuing education courses (category I AMA educational credits) during the past two years.

9.3.12 Complete information as to any pending administrative agency or court cases or administrative agency decisions or court judgments in which the applicant is alleged to have violated or was found guilty of violating any criminal law (excluding minor traffic violations).

9.3.13 Information pertaining to any mental or organic conditions, which may pose a risk to patients.

9.3.14 Details of any prior or pending government agency or third party payer proceeding or litigation challenging or sanctioning the applicant's patient admission, treatment, discharge, charging, correction, or utilization practices, including, but not limited to, Medicare fraud and abuse proceedings and convictions.

- 9.3.15 Recent photographs and a legible copy of a government-issued picture ID. (For security purposes, an applicant must provide a photograph for identification purposes [ref. 100-6].)
- 9.3.16 A current Curriculum Vita.
- 9.3.17 Payment of the application fee.
- 9.3.18 Consents to performance of health screenings (including immunizations/drug testing, as required by Medical Staff or BCH Employee Health policies. (8/12)
- 9.3.19 Completion of a Hospital or Medical Staff orientation. (Physician applicants must complete the Medical Staff orientation.)

9.4 The Medical Staff Department will query the National Practitioner Data Bank, the OIG, relevant databases and primary sources, with regard to a practitioner applying for initial appointment to include a criminal background check. The criminal background check will be conducted as follows:

- 9.4.1 Applicant to complete a release form to conduct a criminal background check.
- 9.4.2 Criminal background checks will be conducted on all applications and will include:
  - a. A Statewide Criminal Court history (Colorado or state of residence within the last two years), to include felony and misdemeanor charges
  - b. Social Security Trace
- 9.4.3 On applications where there are potential issues and/or questions which cannot be resolved or additional concerns arise, a more extensive criminal background check may be conducted and may include any of the following:
  - a. Colorado Statewide Civil Court records
  - b. Colorado Bureau of Investigations arrest records
  - c. Statewide Repository Arrest records
  - d. Federal Criminal Search
  - e. Federal Civil Search
  - f. Out of State Civil Records (upper court, lower court, or both)
  - g. Out of State Criminal history (felony or felony and misdemeanor)
  - h. Military Services
- 9.4.4 Findings from any of the above stated background checks will be utilized to verify the applicant's full disclosure of historical issues, and/or identify other concerns not previously stated in the application.

9.5 Upon receipt of the above, the Medical Staff Department will verify its contents. The provision of information by the applicant containing confirmed significant misrepresentations, misstatements, omissions or inaccuracies in the application or credentialing process, whether intentional or not, and/or failure of the applicant to sustain the burden of producing adequate information, shall result in automatic and immediate rejection of the application. If such misrepresentation, misstatement, omission or inaccuracy is discovered after the applicant has received membership or clinical privileges, such membership and clinical privileges shall be grounds for automatically and immediate termination. Rejection of an application or termination of membership or clinical privileges on the grounds stated in this paragraph shall be an administrative action and shall not entitle the applicant to any procedures under the Fair Hearing Plan or the AHP Manual. If the information revealed as a result of any misstatement, omission or misrepresentation on an application indicates that the practitioner has engaged in unprofessional or criminal conduct as defined by law, the medical staff shall report such conduct to the appropriate agencies as required by law. An applicant may reapply for Medical Staff

membership and clinical privileges, based on this type of administrative action, one year after the rejection or termination was enacted.

9.6 In the event there is undue delay in obtaining the required information, the Medical Staff Department determines that additional information or documentation is necessary to properly evaluate the applicant's qualifications for membership or clinical privileges, or it appears to the Medical Staff Department that the applicant may not meet one or more of the qualifications for membership or clinical privileges, the Medical Staff Department will notify the applicant of the additional information or documentation that is required to determine whether the applicant meets the qualifications for membership or clinical privileges. It shall be the responsibility of the applicant to use his best efforts to assist the Medical Staff Department in obtaining all information necessary to evaluate the applicant's qualifications for membership and clinical privileges and to resolve any doubts or concerns regarding the applicant's qualifications. If the Medical Staff Department has not received the requested information within thirty (30) days after notification to the applicant, it shall not continue to process the application and the time periods for processing shall be tolled. If the applicant provides the required information, the Medical Staff Department shall resume processing the application, unless the application has been removed from consideration for failure to be completed as set forth in paragraph 7 below.

9.7 An application is not deemed complete unless and until (i) all blanks on the application form are filled in and all necessary explanations are provided to the satisfaction of the Medical Staff Department; (ii) all letters of reference and information from former hospitals, department chairs, physicians who have worked with or observed the applicant and other affiliations have been received and are responsive to the satisfaction of the Medical Staff Department; (iii) all information necessary to properly evaluate and address any doubts or concerns regarding an applicant's qualifications has been received by the Medical Staff Department and is consistent with the information provided in the application; and (iv) all other requested information or documentation has been provided. The determination that an application is incomplete shall be made by the Medical Staff Department as the designee of the Chief Executive Officer and is an administrative decision which does not entitle the applicant to any procedural rights under the Fair Hearing Plan, or, if an AHP, the AHP Manual. In addition, a Department Chair, the Credentials or Medical Executive Committees or the Governing Board may, at any time during the credentialing process, request additional information or documentation the Chair, Committees or Board deems necessary to properly evaluate the applicant's qualifications for membership or clinical privileges. It shall be the responsibility of the applicant to provide such requested information or documentation. Failure to provide such documentation within thirty (30) days of the request (or such additional time period as the Chair, Committee or Board may permit) shall be deemed a voluntary withdrawal of the applicant's application and the application shall be withdrawn from further consideration. Withdrawal of the application shall not entitle the applicant to any procedural rights under the Fair Hearing Plan or, if an AHP, the AHP Manual.

9.8 The applicant whose application is not completed within six (6) months after it was received by the Medical Staff Department shall be automatically removed from consideration for membership and/or clinical privileges and no further processing will take place. Such an applicant's application may, thereafter, be reconsidered only upon payment by the applicant of an additional application fee and only if all information therein which may change over time, including, but not limited to, Hospital reports and personal references, have been resubmitted.

9.9 When collection and verification is accomplished and the application is deemed complete by the Director of Medical Staff Department, the Medical Staff Department will notify the applicant, and the file will then be summarized and presented to the appropriate Department Chair(s).

9.10 The completed application will be sent to the applicable department(s), Credentials Committee, Medical Executive Committee, Joint Conference Committee and Governing Board, as described below, for review at the next appropriate regularly scheduled meetings.

9.11 The Department Chair, Credentials Committee, Medical Executive Committee or Governing Board may interview the applicant at any stage in the credentialing process to seek further information from the applicant, clarify any information received or address any questions or concerns regarding the applicant's qualifications for membership and/or clinical privileges. If a Committee or the Governing Board has material reservations regarding the qualifications of the applicant at least one of the Committees or the Board shall interview the applicant before membership and/or clinical privileges are granted. The responsibility to interview an applicant may be delegated to an ad hoc committee appointed by the Credentials or Medical Executive Committees or the Governing Board. An applicant is not entitled at an interview to any of the rights and procedures under the Fair Hearing Plan, including without limitation, the right to be represented by counsel at the interview unless the right or procedure is expressly granted to the applicant at the sole discretion of the interviewing body.

9.12 A permanent record will be made of the interview including the general nature of questions asked, adequacy of answer and the findings of the Department Chair, Committee or group relative to the qualifications of the applicant. The interview will be documented and a copy of the interview results will be placed in the applicant's file. The Medical Staff Coordinator will contact the applicant to arrange the clinical interview and notify the applicant in writing of the date, time and place of such interview.

9.13 The Chair of the Department(s) wherein the applicant has requested clinical privileges shall review the completed application and all related documentation for the purpose of evaluating the applicant to exercise the requested clinical privileges. A Department Chair may ask the applicant for further documentation. This documentation will be added to the applicant's credentials file. A report of the Chair's findings will be forwarded to the Credentials Committee within 30 days of the Chair's receipt of a completed application. In the event a Department Chair is unable to formulate his or her findings within the aforementioned time frame for any reason, the Department Chair will so inform the Credentials Committee and may request a reasonable extension of time.

9.14 The applicant's file will then be reviewed by the Credentials Committee at its next scheduled meeting. The Credentials Committee shall review and evaluate the completed application, together with all related documentation and information, the report(s) of the Department Chair(s) and such other relevant information as may be available. As part of its evaluation, the Committee may conduct an independent investigation of the applicant's qualifications, may interview the applicant and may request further documentation. It shall endeavor to submit its report and recommendation as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations, and scope of clinical privileges to the Medical Executive Committee within sixty (60) days after receipt of the

applicant's file and any additional requested information. The signature of the Chair of the Credentials Committee on the applicable form will indicate the findings and recommendations of the Credentials Committee.

9.15 The Chair of the Credentials Committee or President of the Medical Staff of Boulder will present to the Medical Executive Committee a summary of the applicant's file, the findings of the Department Chair(s) and the findings and recommendations of the Credentials Committee. The Medical Executive Committee shall consider this information at its next regularly scheduled meeting.

9.16 If the vote and recommendation of the Credentials Committee is unanimous in favor of approval, the Medical Executive Committee may forward the recommendation of the Credentials Committee directly to the Governing Board for action.

9.17 Notwithstanding the unanimous approval of the application by the Credentials Committee, any member of the Medical Executive Committee may, for any reason, request that the Medical Executive Committee consider the application and all related documentation and information.

9.18 In the absence of a unanimous recommendation of the Credentials Committee favoring approval of an application, the Medical Executive Committee shall consider the application and all related documentation and information, in addition to the report and recommendation of the Credentials Committee.

9.19 The Medical Executive Committee shall promptly forward its report and recommendation along with the completed application, all related documentation and information and the report(s) and/or recommendations of Department Chair(s) and the Credentials Committee to the Governing Board of the Hospital. All favorable recommendations must specifically recommend the clinical privileges to be granted.

9.20 If the recommendation of the Medical Executive Committee differs from the recommendation of the Credentials Committee in its conclusion, the Medical Executive Committee shall clearly state the reasons and rationale for its differing conclusions and shall cite references in the applicant's record for its disagreement, if possible.

9.21 In addition, the Medical Executive Committee may defer action on the application, may remand it to the Credentials Committee or to the Department(s) for further study or answers to specific questions, or may interview the applicant. Where possible, the Medical Executive Committee should make its recommendation within seventy (70) days of receipt of the application from the Credentials Committee.

9.22 Expedited Process for Granting Membership/Privileges (4/09)

9.22.1 The Board of Directors has delegated to the Joint Conference Committee the authority to render decisions on their behalf for initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges that meet the criteria for expedited privileges. The BOD also delegates to the JCC the ability to approve medical staff forms, policies and/or procedures which have been recommended by the MEC, with prior endorsement by the appropriate medical staff committees, and that are non-controversial or administrative in nature. (BOD 1/12)

9.23 The Joint Conference Committee shall, in whole or in part, adopt or reject the Medical Executive Committee recommendations or may reserve the right to defer action on the application, policy or form and refer the application, policy or form back to the MEC for further interviews, documentation or consideration stating the reasons for such referral and setting a reasonable time within which a subsequent recommendation shall be made. At the next regularly scheduled meeting of the Joint Conference Committee (or appropriate subcommittee), after receipt of such subsequent recommendation, the Joint Conference Committee shall make a decision on the application and/or requested privileges, policy or form.

9.24 If the action of the Joint Conference Committee of the Hospital is favorable to the application, policy or form its action shall be final and notice of its decision shall be forwarded to the Governing Board for their information and given by the Chief Executive Officer to the applicant.

9.25 The new appointee will be notified in writing by the Chief Executive Officer of the action of the Governing Board. The notice shall include (1) a statement that the applicant has been appointed to a particular Medical Staff or AHP category; (2) the Department to which he is assigned; (3) the clinical privileges he may exercise; (4) a summary of his duties as a Medical Staff or AHP appointee; and (5) any special conditions to the appointment. Any other pertinent information regarding appointment to the Medical Staff or as an AHP will either be forwarded or made available to the appointee at this time.

9.26 If the recommendation of the Medical Executive Committee is adverse to the applicant, the Chief Executive Officer of the Hospital shall notify the applicant by certified mail, return receipt requested, of the bases for the adverse decision and the applicant's procedural rights under the Fair Hearing Plan or AHP Manual. The Governing Board shall take final action after the applicant has waived or exhausted the applicable procedural rights under the Fair Hearing Plan or AHP Manual. Action taken thereafter shall be the conclusive decision of the Governing Board

9.27 Following the action of the Joint Conference Committee or Governing Board of any decisions to grant, modify or restrict staff membership and/or clinical privileges, pertinent information regarding the appointment will be forwarded to all appropriate department/units with the hospital. (MEC 4/09)

SECTION 10. CONFLICT RESOLUTION

10.1 Whenever the Governing Board determines that it will decide a matter contrary to the Medical Executive Committee's recommendation, the matter will be submitted to a Joint Conference Committee for review and recommendation before the Governing Board makes its final decision.

SECTION 11. CONFIDENTIALITY

11.1 All records of professional review activities, including, without limitation, all information received or generated in the credentialing process and all records considered or created by a professional review committee or body shall be confidential to the fullest extent provided by state and federal law. Each practitioner involved in professional review and/or credentialing activities, shall keep in strict confidence all papers, reports and information obtained by virtue of

membership on a committee or participation in professional review and credentialing activities. Official minutes of the proceedings are open to all appointees of the applicable committees.

11.2 Due to the increasing amount of materials that must be reviewed by committees, certain minutes and information may be made available to committee appointees prior to a regularly scheduled meeting. These materials and their contents are confidential and the materials must be returned at the relevant meeting or appropriately destroyed. One master copy of all material will be maintained by the Medical Staff Department for review, if necessary.

SECTION 12. PROCESSING TIME FOR INITIAL PRIVILEGES

12.1 Absent unusual circumstances or requests for additional information, an application for membership and/or clinical privileges will usually be reviewed within the following time periods:

Individual/Group	Time Period
Department Chairmen (to review and report)	30 days
Credentials Committee (to reach recommendation)	60 days
Medical Executive Committee (to request additional information and/or make final recommendation)	70 days
Governing Board/Joint Conference Committee (to render final decision)	In a reasonable period of time

12.2 These time periods are guidelines only and do not create any right to have an application processed within these precise periods. If the provisions of the Fair Hearing Plan are activated, the time requirements provided therein govern the continued processing of the application.

SECTION 13. REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF DISCIPLINARY ACTION

13.1 A practitioner who has been the subject of a final adverse action, as defined below, shall not be eligible to reapply for membership and/or the clinical privileges affected by the adverse action for a period of at least three (3) years after the date the adverse action becomes effective.

13.2 A final adverse action, for purposes of this Section VII only, shall mean the following:

13.2.1 Revocation of the practitioner's membership or clinical privileges;

13.2.2 The practitioner's resignation of his membership or relinquishment of his clinical privileges during an investigation of the practitioner’s competence or professional conduct or following a recommendation by the Credentials or Medical Executive Committees or action by the Governing Board to suspend, revoke or restrict the practitioner's membership or clinical privileges;

13.2.3 A final decision by the Governing Board to deny all or any portion of an applicant's request for

13.2.4 membership and/or clinical privileges (including without limitation a request by a current practitioner for increased clinical privileges);

13.2.5 An applicant's withdrawal of all or any portion of his request for membership and/or clinical privileges (including without limitation a request by a current member or practitioner for increased clinical privileges) during an investigation of the practitioner's competence or professional conduct or following a recommendation by the Credentials

or Medical Executive Committee or action by the Governing Board to deny all or any portion of the applicant's request for membership or clinical privileges; or

13.2.6 A practitioner's failure to reapply for membership and/or clinical privileges after an automatic resignation as set forth in Article III, Section 3 of the Fair Hearing Plan.

13.3 For the purpose of this, an adverse decision shall be effective when:

13.3.1 all hearing, appellate review, and other quasi-judicial proceedings conducted by the Hospital, if any, bearing on the decision are completed, or

13.3.2 all judicial proceedings, if any, bearing upon the decision which are filed and served within eighteen (18) months after the completion of the Hospital proceedings are completed, whichever is later.

13.4 An individual who has been the subject of a final adverse action, as defined above, may request an application for membership and/or clinical privileges after the three-year period has expired. Such individual shall not be eligible to reapply for membership and/or clinical privileges unless he:

13.4.1 meets the eligibility criteria set forth in Section IV of this Manual;

13.4.2 demonstrates that the basis for the earlier adverse action no longer exists and/or that the individual has successfully completed rehabilitation in the areas which formed the basis for the previous adverse action; and

13.4.3 demonstrates that he has complied with all the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions.

13.5 The individual must document all professional activities and all educational, training, proctoring and other rehabilitation activities in which he has engaged since the date of the final adverse action. For each professional activity, the individual must furnish a letter from someone who observed the individual's performance in the activity indicating that the basis for the earlier adverse action no longer exists. For each educational, training, proctoring or other rehabilitation activity, the individual must furnish a letter or other documentation that the individual successfully completed the rehabilitation, education or training activity and that the individual is rehabilitated in the areas which formed the basis for the adverse action.

13.6 An individual who does not meet the eligibility criteria set forth in Section IV, or is unable to provide the documentation required in paragraph 5 above, shall not be eligible to reapply for membership and/or clinical privileges. The Director of Medical Staff Department shall determine whether the individual has met the eligibility criteria or has furnished the requisite documentation. Such determination is an administrative decision and shall not entitle the individual to any of the procedures under the Fair Hearing Plan, or, if an AHP, under the AHP Manual.

13.7 If an individual meets the eligibility criteria and furnishes the requisite documentation, the Credentials Committee shall review all information submitted by the individual regarding his eligibility to reapply for membership or clinical privileges. If the Credentials Committee determines that the individual is eligible to reapply for membership and/or clinical privileges, the individual shall be provided with an application. If the Credentials Committee determines that the individual is not eligible to reapply, it shall so notify the individual. The individual may request an interview with the Credentials Committee or, at the Credentials Committee's discretion, with an ad hoc committee appointed by the Credentials Committee. After such

interview, if one is requested, the Credentials Committee shall make a recommendation to the Governing Board. The Governing Board shall make the final decision whether an individual is eligible to reapply for membership or clinical privileges. Such decision shall not entitle the individual to any procedures under the Fair Hearing Plan or the AHP Manual, except that the individual may request an interview with the Governing Board, or at the Governing Board's discretion, an ad hoc committee, in the event the Governing Board's final decision is adverse to the individual and contrary to the recommendation of the Credentials Committee.

13.8 If an individual is permitted to reapply for membership and/or clinical privileges, such application shall be treated in the same manner as an initial application and shall be subject to all provisions of this Manual applicable to the processing of an initial application.

SECTION 14. PROCTORING

14.1 Proctoring is the process through which skills and/or knowledge that a practitioner asserts he/she *already possesses* are confirmed. All practitioners who are granted privileges may be subject to proctoring with respect to high risk/problem prone procedures, concerns of quality issues or other issues as deemed necessary. Routine proctoring is accomplished and monitored through the quality and peer review process of the Medical Staff.

14.2 Proctoring Assignment

14.2.1 The practitioner shall comply with specific proctoring requirements identified by the department to which he is assigned. A proctor who has the same or comparable privileges as the practitioner will be assigned as the primary proctor. A partner or associate of the practitioner may also be assigned as a proctor but shall not proctor more than 50% of the practitioner's cases.

14.2.2 Proctoring forms or such other documentation of proctoring acceptable to the Medical Staff Department will be completed by all proctors. Proctoring forms will be submitted to the Medical Staff Department and the applicable Department Chair(s). It shall be the responsibility of the practitioner to assure that all proctoring forms are submitted in a timely fashion.

14.2.3 When the practitioner has completed applicable requirements for proctoring, the Medical Staff Department will provide all documentation of proctoring to the Credentials Committee.

14.2.4 The Credentials Committee may approve exceptions to the proctoring requirements stated on the core privileges forms for good cause upon the request of a practitioner or department or upon the Committee's own motion.

SECTION 15. REAPPOINTMENT PROCEDURE

15.1 All appointments of membership and/or clinical privileges are for a period not to exceed two years.

15.2 A practitioner shall not be eligible for reappointment to the Medical Staff or renewal of the practitioner's clinical privileges unless the practitioner demonstrates that he continues to meet all the applicable qualifications and eligibility requirements for membership and clinical privileges set forth in Section IV of this Manual. Notwithstanding the foregoing, a practitioner applying for appointment whose professional license has been suspended or whose privileges at

another hospital have been revoked or suspended shall not be ineligible to apply for reappointment, but the circumstances of the revocation or suspension shall be considered in determining whether the practitioner continues to meet the qualifications for membership and/or clinical privileges.

15.3 At least 150 days prior to the expiration date of each practitioner's appointment, the Medical Staff Department shall mail a reappointment application to the Medical Staff member. This application form shall be completed and returned to the Medical Staff Department not later than thirty (30) days after the practitioner's receipt of the application. If the reappointment application is not returned to the Medical Staff Department within this 30 day time period, the practitioner will be notified by certified mail that he/she must return the reappointment application within 30 days of receipt of the certified letter. The reappointment application must be received within this time period in order to process the reappointment prior to expiration of current appointment.

15.4 Failure, without good cause as determined by the Credentials Committee or MEC, to complete and return the reappointment application within these sixty (60) days, may result in a delay in the approval of the application and the expiration of the current appointment. If the practitioner submits the completed reappointment application after sixty (60) days but prior to the expiration of his current appointment, the application will be processed for reappointment. However, if the current appointment expires prior to approval, his staff membership and/or clinical privileges shall, in effect, be automatically suspended until such time as his reappointment has been approved. A practitioner whose membership and/or clinical privileges are so expired shall not be entitled to any procedural rights under the Fair Hearing Plan, or AHP Manual.

15.5 Failure, without good cause as determined by the Credentials Committee or MEC, to complete and return the reappointment application prior to the expiration shall result in the current appointment expiring. This expiration of appointment, shall, in effect, be considered a voluntary resignation. If the practitioner wishes to resume membership and clinical privileges, an initial application will need to be ~~re~~submitted. A practitioner whose membership and/or clinical privileges are so resigned shall not be entitled to any procedural rights under the Fair Hearing Plan, or AHP Manual.

15.6 The provisions of Section V, paragraph 2 of this Manual regarding the affect of the initial application shall apply to the reappointment application.

15.7 The Medical Staff Department shall query the National Practitioner Data Bank and other relevant databases, with regard to a practitioner applying for reappointment.

15.8 The Medical Staff Department shall collect from the practitioner's credentials file and other relevant sources cumulative information regarding the individual's professional activities, current competence, performance and conduct in the Hospital and/or other hospitals at which the practitioner has privileges. Such information shall include, without limitation, the following:

15.8.1 patterns of care as demonstrated in findings of quality assurance activities;

15.8.2 medical records/hospital reports;

15.8.3 continuing medical education activities;

15.8.4 any prior corrective action investigations, proceedings, recommendations or actions at the Hospital or at other facilities at which the practitioner practices;
15.8.5 service on Medical Staff, Department, and Hospital Committees as requested;
15.8.6 timely and accurate completion of medical records;
15.8.7 ability to work cooperatively with others in the Hospital setting in a consistently cordial and productive manner;
15.8.8 compliance with all applicable bylaws, policies, rules, regulations and procedures of the Hospital and the Medical Staff;
15.8.9 appropriate utilization of Hospital resources;
15.8.10 cumulative results of any Department or Section evaluations, quality management or professional review activities, medical staff monitoring functions, including, but not limited to, monitoring and evaluation of the quality and appropriateness of care, surgical case review, drug usage evaluation, the medical record review function, blood usage review and the pharmacy and therapeutics function;
15.8.11 any mental or organic conditions which pose a risk to patients;
15.8.12 proof of health screening/immunization as required by Medical Staff or Board policy;
15.8.13 other information relevant to assessing the practitioner's qualifications for continued membership and clinical privileges.

15.9 The requirements of Section VI. of this Manual, including without limitation, the requirements for completion of an application and the consequences for misstatements or omissions in an application, shall apply to applications for reappointment.

15.10 The Medical Staff Quality Coordinator will compile a quality review summary of known clinical activity for each practitioner due for reappointment.
15.10.1 The quality review summary will be attached to the reappointment application.
15.10.2 When the final determination regarding reappointment is made by the Governing Board and the reappointment application is ready to be filed in the practitioner's Credentials File, the quality review summary will be removed from the reappointment application and will be filed in the practitioner's quality review file in the Medical Staff Department. The quality review summary is both a peer review and a quality management record and is confidential and privileged under state and federal law.

SECTION 16. PROCESSNG APPLICATIONS FOR REAPPOINTMENT

16.1 Practitioners applying for reappointment of membership and/or clinical privileges must be able to present documentation that, at the time of application for reappointment, the practitioner continues to meet the qualifications for membership and/or clinical privileges based on current and cumulative information regarding the following:
16.1.1 current licensure (if applicable);
16.1.2 current board certified by a recognized ABMS member board or must attain ABMS member board certification within five (5) years of completion of training program. (MEC 4/09)
16.1.3 compliance with applicable continuing medical education related to the practitioner’s specialty and or privileges;
16.1.4 compliance with applicable continuing medical education related to the practitioner’s specialty and or privileges;

16.1.5 confirmation of current physical and mental health status free from any significant physical, emotional or behavioral impairment which prevents the practitioner from meeting the qualifications for continued membership and clinical privileges. The discretion rests with the Department Chair, the Credentials Committee or the Medical Executive Committee to require a physical and/or mental health examination of the practitioner;

16.1.6 ethical behavior, professional performance and current competence based in whole or in part upon results of quality assurance activities and reports and further evidenced by documentation of his professional performance in the Hospital;

16.1.7 appropriate clinical and professional judgment based in whole or in part upon results of quality assurance activities and reports and further evidenced by documentation of his professional performance in the Hospital;

16.1.8 clinical and/or technical skills, as indicated in whole or in part by the results of quality assurance activities and reports and further evidenced by documentation of his professional performance in this or any other Hospital;

16.1.9 disciplinary action, including without limitation, reprimands, warnings, revocation, suspension or restriction regarding the practitioner's licensure, certification or registration (i.e., state or Drug Enforcement Administration) or the voluntary relinquishment of such licensure, certification or registration;

16.1.10 voluntary or involuntary termination of membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at the Hospital or at another hospital;

16.1.11 involvement in any liability claims or actions with final judgments or settlements;

16.1.12 compliance with the Hospital and Medical Staff bylaws, rules and regulations and

16.1.13 Department policies, attendance at Medical Staff, Department and Committee meetings and cooperation with and participation in Medical Staff Committees and other committees of the Hospital, if required or requested;

16.1.14 conduct at the Hospital, including the ability to work cooperatively with others in a

16.1.15 consistently cordial and productive manner and compliance with all Hospital polices regarding behavior in the Hospital;

16.1.16 written evidence of the malpractice insurance required by the Governing Board of the Hospital;

16.1.17 the information gathered by the Medical Staff Department pursuant to Section IX, paragraph 7 above;

16.1.18 proof of screening/ immunization as required by Medical Staff or Board policy;

16.1.19 any other reasonable indicators of qualifications or any other information that may be requested by the various Medical Staff Committees;

16.1.20 agreement, documented by signature on the reappointment application release form, to participate in the Organized Health Care Arrangement ("OHCA") established by Boulder Community Health and the Medical Staff of Boulder.

16.2 The applicant shall have the burden of providing accurate and adequate information to allow the Medical Staff and Governing Board of the Hospital to evaluate his current competency and qualifications for reappointment.

16.3 If the applicant has had insufficient activity at the Hospital to properly evaluate his application for reappointment, additional information may be requested from other hospitals where he has privileges. If the practitioner does not meet the requirements applicable to his current Medical Staff category, the Medical Staff Department shall recommend to the Credentials Committee

that the practitioner be reassigned to the appropriate category for which he is qualified. If the Credentials Committee agrees with such recommendation, the practitioner shall be notified and the application for reappointment shall be processed as an application for reappointment to the new Medical Staff category. Reassignment to a different Medical Staff category is an administrative action and does not entitle the practitioner to any procedures under the Fair Hearing Plan or AHP Manual.

16.4 The completed application for reappointment and all supporting documentation shall be forwarded for consideration, first to the clinical Department Chair(s) and then to all other applicable reviewing bodies. Processing of requests for reappointment follows the same procedure for consideration of an application for initial appointment as set forth in this Manual, with final approval resting with the Governing Board of the Hospital.

16.5 Department Action:

16.5.1 The Chair of the Department in which the practitioner has been assigned shall gather information and/or confer with all Chairs of Departments where the applicant requests or has exercised privileges in order to compile his report on the practitioner's performance. The Chair shall transmit his written report concerning the reappraisal of the full range of clinical privileges held by the practitioner to the Credentials Committee. A separate report must be submitted for each applicant. The assessment of the practitioner's performance will include reviews of the practitioner's file as described above, completed Ongoing Professional Practice Evaluations during the reappointment cycle, a statement as to whether or not the Chair knows of, or has observed or been informed of any conduct which indicates that the practitioner does not meet the qualification for membership and whether, to the Chair's knowledge, the practitioner has fulfilled all Medical Staff obligations and properly exercised his clinical privileges during the prior appointment period. In the event an applicant's volumes are too low to assess competence, a peer reference will be requested from the Department Chair from another hospital or surgery center where the applicant practices.

16.6 Credentials and Medical Executive Committee Action:

16.6.1 Following the receipt of the Department Chair's written report concerning the application for reappointment, the Credentials Committee shall review the practitioner's file, the Department Chair's report and all available and relevant information and shall make a recommendation to the Medical Executive Committee for reappointment, or non-reappointment and for staff category, department assignment or changes in clinical privileges. The Medical Executive Committee shall forward its recommendations to the Governing Board.

16.7 Limited Period of Appointment:

From time to time, the Medical Executive Committee may recommend a period of appointment of less than two (2) years. Such appointment is not an adverse action and shall not entitle the practitioner to a hearing or other procedures under the Bylaws Fair Hearing Plan or other policy. A limited appointment may be extended without completion of a new application and review required by these Bylaws provided that a reappointment application is completed and processed within two years. The practitioner will submit a supplemental application and any other requested information, which will be reviewed, along with any additional information deemed appropriate, by the Department.

16.8 Governing Board Action:

16.8.1 The procedures for action on an application for reappointment shall be the same as those for initial appointment.

16.9 Request for Modification of Appointment Status or Privileges:

16.9.1 A practitioner, either in connection with reappointment or at any other time may request modification of his staff category, department assignment, or clinical privileges by submitting a written request to the respective department(s) and forwarded to the Credentials Committee. Requests for modification of department assignment shall be reviewed by the Credentials Committee. Requests for modification of a Medical Staff category shall be reviewed by the Credentials Committee and are subject to approval by the Governing Board. Denial of a request for modification of department assignment or Medical Staff category shall not constitute an adverse action and shall not entitle the practitioner to any rights under the Fair Hearing Plan. All requests for increased privileges must be accompanied by information demonstrating current clinical competence in the specific privilege requested. Requests for increased privileges shall be treated in the same manner as an initial application. There will be an exception for resignations, which will be processed immediately and noted on the Credentials Committee report.

SECTION 17. PROCESSING TIME FOR REAPPOINTMENT

17.1 Absent unusual circumstances or requests for additional information, an application for membership will usually be reviewed by the following individuals and groups within the following time periods:

Individual/Group	Time Period
Department Chairmen (to review and report)	30 days
Credentials Committee (to reach recommendation)	60 days
Medical Executive Committee (to request additional information and/or make final recommendation)	70 days
Governing Board/Joint Conference Committee (to render final decision)	In a reasonable period of time

17.1.1 These time periods are guidelines only and do not create any right to have an application processed within these precise periods. If the provisions of the Fair Hearing Plan are activated, the time requirements provided therein govern the continued processing of the application

SECTION 18. CONDITIONAL REAPPOINTMENT

18.1 If the performance or conduct of a practitioner raises concerns regarding the practitioner's judgment, conduct or other qualifications, a conditional reappointment may be imposed. A reappointment is considered conditional if it impacts his/her Medical Staff membership or privileges.

18.2 The Credentials or Medical Executive Committees may recommend, or the Governing Board may determine on its own motion, conditional reappointment for any practitioner if concerns regarding the practitioner are identified at any stage of processing the practitioner's application for reappointment.

18.3 The conditions imposed in a conditional reappointment may be related to any concerns regarding the practitioner identified by the Credentials or Medical Executive Committees or the Governing Board, or may consist of a reappointment for a specified period of time.

18.4 The Chief Executive Officer shall inform a practitioner in writing of any conditions imposed on the practitioner's reappointment and that failure to abide by the conditions of reappointment or any other infraction of Hospital or Medical Staff Bylaws, policies, rules or regulations shall result in re-evaluation of the practitioner's reappointment and may result in corrective action, up to and including revocation of membership and/or clinical privileges.

18.5 Conditional reappointment shall not entitle the practitioner to any rights under the Fair Hearing Plan, unless the conditions restrict the practitioner's exercise of clinical privileges during the period of reappointment in a manner that would otherwise entitle the practitioner to rights under the Fair Hearing Plan.

SECTION 19. CLINICAL PRIVILEGES

19.1 A Practitioner providing clinical services may exercise only those specific privileges granted to him by the Board or emergency privileges as described herein. These privileges shall be hospital-specific, within the scope of the Practitioner's current competence and shall be subject to the rules of the Department and/or Medical Staff. Core privileges for each specialty generally include Admission, work-up, diagnosis and treatment or consultative services and include services for patients of all ages, except as specifically noted within delineations of privileges. Each Practitioner must obtain consultation with another appropriate practitioner in any case when the clinical needs of the patient exceed the privileges of the Practitioner currently attending to the patient; or when consultation is required by rules, guidelines or protocols.

19.2 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, demonstrated competence and, as applicable, compliance with any requirements established by the Hospital. Valid, complete requests for clinical privileges shall be evaluated on the basis of education, training, experience, demonstrated competence, ability and judgment and other qualifications the Hospital deems applicable.

SECTION 20. TEMPORARY CLINICAL PRIVILEGES (10/23/13 JCC)

20.1 Upon written request and documentation of a patient care need, the CEO or designee, on the recommendation of the Medical Staff President or designee, may grant temporary privileges to cover a needed hospital service to attend patients without applying for membership on the medical staff (with the exception of 20.1.4 below). Specifically, temporary privileges may be granted for the following:

20.1.1 The care of a specific patient(s);

20.1.2 An individual an individual serving as a locum tenens for a member of the medical staff who is on vacation, attending an educational seminar, ill, and/or needs coverage assistance for a short period of time; an individual providing specialty coverage when a shortage of specialists is identified.

20.1.3 The purpose of proctoring; or

20.1.4 An applicant with a complete and clean application awaiting review by the MEC and board, following a favorable recommendation by Department Chairman and/or Credentials Committee.

20.2 For purposes of temporary clinical privileges, an application shall be considered upon verification of the following:

20.2.1 complete application

20.2.2 current licensure

20.2.3 relevant training or experience

20.2.4 current competence

20.2.5 ability to perform the privileges requested

20.2.6 NPDB

20.2.7 adequate professional malpractice insurance

20.2.8 current DEA

20.2.9 affiliations (for locum tenens, a minimum of the previous 5 placements will be acceptable if no questionable responses are received).

20.2.10 complete Background Check

20.3 An application shall be considered clean if the applicant has:

20.3.1 No current or previously successful challenges to his or her licensure or registration;

20.3.2 No subjection to involuntary termination of medical staff membership at another organization;

20.3.3 No subjection to involuntary limitation, reduction, denial, or loss of clinical.

20.3.4 No subjection to Medicare/Medicaid Sanctions

20.3.5 No record of an excessive number of professional liability actions, or any one significant judgment/settlement.

20.3.6 Signed attestation agreeing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

20.4 Time Limited

20.4.1 Temporary privileges shall be granted for a specific period of time, as warranted by the situation, but shall not exceed one hundred and twenty (120) days.

20.4.2 Temporary privileges shall expire at the end of the time period for which they are granted.

20.4.3 A practitioner providing a specific patient care need (one-time only), will be granted permission to practice only during the specific, documented, timeframe services are to be provided.

20.5 Termination of Temporary Clinical Privileges

20.5.1 If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Chief Executive Officer, the appropriate department Chair, or the President of the Medical Staff may immediately terminate all temporary privileges. The appropriate department Chair, or the President of the Medical Staff shall assign to another Medical Staff member responsibility for the care of such terminated individual's patients until they are discharged. Whenever possible,

consideration shall be given to the wishes of the patient in the selection of a substitute physician.

20.5.2 The granting of temporary privileges is a courtesy which may be extended by the Hospital. Temporary privileges may be terminated for any reason.

20.5.3 Neither the granting, denial, or termination of temporary privileges shall entitle the individual to any of the procedural rights provided in this policy.

20.6 Emergency/Disaster Situations

20.6.1 **Immediate:** In the case of an emergency in which serious or permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any Medical Staff member or practitioner with clinical privileges at the Hospital is authorized and will be assisted to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the individual's license or certification regardless of department affiliation, staff category or delineated privileges. An individual exercising emergency privileges is obligated to summon all consultative assistance deemed necessary to save a patient from such danger and to arrange for appropriate follow up care.

20.6.2 **Disaster:** Emergency privileges may be granted to licensed independent practitioners (LIP) when the emergency management plan has been activated and the Medical Staff is unable to handle the immediate patient needs. Processes to ensure verification of identity, licensure and competence, as well as oversight of the care, treatment and services provided are delineated in the Medical Staff's Disaster Response Protocol (MS Policy #107).

20.7 Proctoring

20.7.1 Temporary privileges for proctoring are intended for physicians and other practitioners who do not currently hold staff membership/privileges. Proctoring may involve direct observation or retrospective review by a practitioner who is experienced in the area of expertise or procedure(s) being performed by another practitioner. It is a reliable way to assess current competence in performing the clinical privileges granted and provides an assessment of the practitioner's clinical judgment, skills, and technique.

SECTION 21. TELEMEDICINE PRIVILEGES

21.1 Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care, from a distance, which result in a written or documented medical opinion and affects the medical diagnosis or treatment of a patient. The Medical Staff shall define which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards. Practitioners who wish to provide telemedicine services in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient independently, without clinical supervision or direction from a Medical Staff member must be granted appropriate clinical privileges to do so.

SECTION 22. INTERDEPARTMENTAL PRIVILEGES AND PROCEDURES

22.1 Criteria for procedures that cross specialty lines will be the comparable. Representatives of the specialties involved should collaborate to develop standard criteria by considering resources such as ABMS statements, white papers, community standards, BCH expertise, etc.

22.2 If no agreement can be reached, the recommendations of each specialty involved will be forwarded to the Credentials Committee. After evaluation of this information, the Credentials Committee will forward its recommendation to the MEC. If they cannot finalize a recommendation, the opinions of each specialty will be submitted to the MEC. The MEC will then evaluate the recommendations and/or opinions submitted by the specialties involved and the Credentials Committee, and forward its recommendation to the Governing Board. Based on this report, the Governing Board will grant final approval of the interdepartmental procedure criteria in question.

SECTION 23. COMMUNITY BASED WITHOUT CLINICAL PRIVILEGES (MEC 11/2011)

23.1 Eligibility/Qualifications Criteria:

- 23.1.1 Must maintain a valid Colorado Medical License
- 23.1.2 Must meet the malpractice insurance coverage requirement of $1/$3M.
- 23.1.3 Are subject to the standards of behavior as outlined in the code of professional conduct, when entering BCH premises.
- 23.1.4 Are not required to be board certified.
- 23.1.5 Are not required, for membership application or reappointment to the medical staff, to provide a reference or affiliation verification.
- 23.1.6 Are not required to provide a covering physician.
- 23.1.7 Are not required to maintain a copy of their DEA license on file since they may not exercise prescriptive authority while visiting patients at BCH.
- 23.1.8 Are not required to submit a delineation of privileges form, as no clinical privilege is granted for this category. Similarly, members of this category are exempt from an OPPE and FPPE process.
- 23.1.9 NOTE: Should a community based member desire to become a member with clinical privileges, all requirements as outlined under Section 2 of these bylaws would apply.

SECTION 24. LEAVE OF ABSENCE

24.1 If a Medical Staff Member will be absent from patient care responsibilities for more than six (6) months, he/she must request a leave of absence from the Medical Staff. A member who is absent from patient care responsibilities for more than six (6) months and has not requested a leave of absence shall be deemed to have voluntarily resigned from the Medical Staff, and must reapply for Medical Staff membership and privileges.

24.2 In accordance with the general regulations of the Medical Staff, a practitioner may request a leave of absence by giving written notice to the Medical Staff Department for transmittal to the appropriate Department Chairman and the Chief Executive Officer. The notice must state the period of time, an explanation of the reason for the request and dates requested for the leave, which may not exceed six (6) months, but may be extended up to an additional six (6) months. Absence for longer than such period shall constitute automatic relinquishment of Medical Staff appointment and clinical privileges. If the leave of absence is approved by the Board, the

practitioner's clinical privileges, prerogatives and responsibilities are, in effect, suspended, but he/she shall be responsible for payment of dues unless waived by the Medical Staff.

24.3 If the leave of absence was for medical reasons, then the member must submit a report from his or her attending physician indicating that the member is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested.

24.4 The practitioner must, at least thirty days prior to the termination of the leave, or may at any earlier time, request reinstatement.

24.5 If the member's reappointment period falls while the member is on a leave of absence, the member is subject to the reappointment process as described in the Credentialing Manual.

24.6 The practitioner must submit an application for reinstatement, or an application for Initial Appointment if the current appointment is expired. Either application must include a written summary of relevant activities during the leave including a letter from the chief of staff at all institutions where clinical privileges were held during the leave, if so requested by the Medical Executive Committee or Governing Board. If clinical privileges were not held, the practitioner may be asked to provide documentation of chronological activity.

24.7 The practitioner may also be asked to appear for a personal interview with the Credentials Committee or another committee.

24.8 The Credentials and Medical Executive Committees shall make recommendations to the Governing Board concerning reinstatement. Failure, without good cause, to request reinstatement or to provide documentation of chronological activity shall be deemed to be a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A request for membership and/or clinical privileges subsequently received from a practitioner so terminated shall be submitted and processed in the same manner specified for application for initial appointments.

SECTION 25. USE OF TERMS

25.1 When used herein the terms "Department", "Chairman", "Credentials Committee Chairman", "Chief Executive Officer", "Chief of Staff", "Medical Staff Coordinator", "Medical Staff Department Director", and "Governing Board" are construed to include their "designee(s)".

SECTION 26. ADOPTION/CORRECTION/REVISION OF MANUAL

26.1 Corrections/Revisions.

26.1.1 Minor corrections or revisions may be made to the manual by the Medical Staff Department when such correction or change is necessary due to spelling, punctuation, grammar, context or if required by law. No prior notice of Medical Staff or Board approval of such change is required.

26.1.2 All substantive proposed changes will be posted for the review of the Medical Staff. Any written comments shall be forwarded to the Medical Executive Committee.

26.2 Amendment.

26.2.1 Any amendment to this document shall be approved by the Credentials Committee, the Medical Executive Committee and the Governing Board.

26.3 The procedures outlined in the Medical Staff and Hospital Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt and recommend Medical Staff Bylaws and amendments thereto apply as well to the formulation, adoption and amendment of this Credentialing Manual.

SECTION 27. CREDENTIALING POLICIES

100-1 Health Status Examinations

100-2 Release of Information

100-3 New Procedure Policy (Development of Criteria)

100-4 In-House Training

100-5 Competency Evaluations of AHPs

100-6 Identification of Applicants

100-7 Expedited Process for Granting Membership/Privileges

100-8 Health Screening

HEALTH STATUS EXAMINATIONS

Responsibility: Departmental, Credentials and/or Medical Executive Committee(s)

Purpose: To gather and assess information, to the best of the facility's ability, regarding practitioner's health status at the time of application and/or reappointment to the Medical Staff of Boulder, Boulder Community Health .

Procedure: If, at any time, the applicable departmental committee, Credentials Committee or the Medical Executive Committee identifies a possible mental or physical problem that may adversely impact the practitioner's privileges/practice, any of those aforementioned committees shall have the right to request the practitioner to submit to a mental and/or physical examination. The committee(s) may request a letter from the practitioners' primary care physician in lieu of mental or physical examinations addressing any concerns that may impact patient care delivery skills. This is subject to appeal to the Medical Executive Committee. Failure to respond to this request may result in automatic suspension, denial and/or termination of the practitioner’s privileges or application for privileges at the Hospital, and shall not entitle the practitioner to any rights under the Fair Hearing Plan.

Policy Approved: Governing Board: 5-28-91; reviewed 9-05

RELEASE OF INFORMATION

Responsibility: Credentials Assistant, Medical Staff Coordinator, Director of Medical Staff Department.

Purpose: To maintain confidentiality in compliance with any applicable state and federal laws.

Procedure:

1. APPLICATION AND/OR CREDENTIALS FILE
Practitioners may call or write to request information regarding the status of their application or regarding information contained within their application or credentials file.

   A. A practitioner is entitled to view or receive a copy of any document which he/she personally has provided to the Medical Staff Department.
   B. A practitioner is not entitled to review or receive copies of any reference letters, reference questionnaires or other similar peer review information, which has been provided by another peer or entity. Peer review documents are protected by state and federal laws.
   C. A practitioner may approve the release of certain information contained within his credentials file by signing an appropriate written release.
   D. A practitioner may have access to portions of their credentials file only after they have provided twenty-four (24) hour notice to the Medical Staff Department.

2. CHAIRPERSON'S ACCESS FOR REVIEW - In conjunction with the performance of peer review activities, department chairpersons (or their designee i.e., vice-chairman) may review applications for privileges within their department as the need arises or they may review the credentials file of any departmental member, which they deem necessary. Twenty-four (24) hour notice must be provided to the Medical Staff Department before a file can be reviewed.

3. OTHER'S ACCESS FOR REVIEW - Any practitioner involved in a Medical Staff or departmental committee which has peer review responsibilities will have appropriate access to files during regularly scheduled meetings. Requests to access files during unscheduled periods must be made twenty-four (24) hours in advance. Such access shall be for the sole purpose of performing peer review activities.

4. REVIEW BY APPLICANT OR CURRENT MEDICAL STAFF MEMBER - An applicant or member may only review (or have copied) information for his/her file, which he/she has personally provided.

5. Other interested third parties (i.e., medical facilities, medical staff members, potential partners, etc.) are not entitled to any information with regard to a practitioner (i.e., status of an application, content of the information received,

etc.) from any credentials file, unless a specific release has been signed by the practitioner which outlines the specific information that the Medical Staff Department may release to that party. A facility requesting information will provide a current release signed by the practitioner (within the past six months). Inquiries with no release attached or with an inappropriate release will be returned unanswered to the inquiring person or facility with a note advising the person/facility that a valid release is required in order to comply with the request.

6. The only information that can be given to a third party (i.e., other facility, the public, patients) without a release are the dates on staff and membership category.

Policy Approved: Governing Board, 11-96, reviewed 9-05

NEW PROCEDURE POLICY
(Development of Criteria)

Responsibility: Joint Conference Committee, Medical Staff of Boulder and Medical Staff Department

Purpose: To maintain the quality of care provided to patients at Boulder Community Health by assuring that clinicians have the proper credentials to perform new procedures and to allocate necessary resources for education, equipment and training.

Policy: Clinicians may perform new procedures in the hospital only after the Joint Conference Committee and the Clinical Quality Value Analysis Committee has deemed the new procedure appropriate to be performed at BCH and also after appropriate credentialing criteria has been established.

Procedure: **APPLICANT WILL BE REQUIRED TO:**

1. Complete the appropriate application form. The applicant must be in good standing at the hospital, including but not limited to, no restrictions of practice privileges.
2. Provide a written summary of the proposed procedure and any additional documentation deemed necessary. Applicant will identify resources, education and training necessary to perform the new procedure efficaciously and in a safe manner. This information will be shared with the director and/or vice-president of the clinical service to provide input for budgetary consideration. Applicant will provide proof of appropriate liability coverage.
3. Comply with all hospital and Medical Staff rules and regulations and policies and procedures.
4. The Medical Staff Department Chairman and/or Committee may be requested by Joint Conference Committee to provide evaluation of the application. This may include development of credentialing criteria and quality monitors.
5. If the Joint Conference Committee approves a new procedure to be performed at BCH, development of credentialing criteria and quality monitors will be implemented through the Credentials Committee.
6. Approval from Joint Conference Committee for a new procedure to be performed at BCH does not signify the practitioner has been granted the privilege. The practitioner must apply and be granted the privilege, once criteria has been developed and approved by the Hospital Governing Board. Denial of a new procedure will not entitle the practitioner to any rights under the Fair Hearing Plan.

Approved: Governing Board - 5/10/96; reviewed 9-05

New Procedures/Equipment/Techniques Request Form

In support of Credentialing Policy #100-3, upon identifying a new technology, procedure or diagnostic test for a clinical condition the practitioner is required to take the following actions:

1. Notify the Medical Staff Department of their interest in pursuing a new procedure or using new equipment for the first time at BCH. The worksheet below is intended to include comprehensive information regarding the procedure, (i.e. its potential benefits, increased risks, additional nursing aspects, revisions to usual medications, etc.). Assistance with completing this form is available. Ample time for adequate consideration is required.
2. Upon receipt of this worksheet, the Department will consult with the appropriate Medical Staff leadership and hospital administration. It will then be determined whether or not the technique is a significant change from current standard of care. If it is determined to not be a remarkable deviation, no further action is required by the Medical Staff; however, the practitioner will be required to collaborate with patient care services personnel to ensure that the necessary training, supplies, etc. are in place. The practitioner will be expected to assist in developing an appropriate tracking/review process to ensure adequate evaluation of the new procedure or instrumentation, for an appropriate amount of time/volume.
3. Should it be determined that this new technique is sufficiently complex and a significant change to current practices at BCH, the credentialing process will be established. This process would include development of appropriate privileging criteria and a scope of practice.

Physician name: (please print) ____ **Date:**___________

1. What new technology/innovation are you interested in using or introducing (*device, instrument, new modality, new approach)?* ______________________________
2. What clinical conditions might this be used for? ______________________________
3. How does this offer a patient a significantly better alternative than existing methods/equipment? ______________________________
4. Will this replace or be in addition to present technology? ______________________________
5. Will additional pharmaceuticals, OR supplies, surgical instruments, etc., be required? Yes □ No □
6. Will the use of this technology, procedure, or diagnostic test require an operating or procedure room setup that is different from the norm? Yes □ No □
7. Will the supporting staff (physician & nursing) need special/additional education? Yes □ No □ If yes, please explain: ______________________________
8. How is the use of this technology/innovation reimbursed (l*ist pertinent CPT codes)?* ______________________________
9. How often might this be used at BCH over the next year? ______________________________
10. Where is the technology/innovation currently in use *(reference physicians/hospitals)?* ______________________________
11. What, if any, additional staff will be required? ______________________________
12. Outline the qualifications/training needed to safely use this technology/innovation: ______________________________
13. Disclose any possible conflicts of interest *(i.e. on speaker's bureau for manufacturer; have a proprietary interest in company; own stock in company; receive royalties from company; receive research funding from company):* ______________________________
14. **The following items (if applicable) must be submitted with this form.**
    a. Peer reviewed and clinically researched outcome data relating to the proposed technology, procedure, or diagnostic test.
    b. Course materials
    c. Manufacturer's materials
    d. FDA approval for clinical use

Return completed form to the Medical Staff Department or fax to 303-415-7498.

IN-HOUSE TRAINING POLICY

Responsibility: Joint Conference Committee, Medical Staff of Boulder and Medical Staff Department

Purpose: To maintain the quality of care provided to patients at Boulder Community Health by assuring that clinicians have the proper credentials and sponsorship to participate in an in-house training program not readily offered in a formal educational setting at another institution.

Policy: Clinicians may be trained in the hospital under the direct training and supervision of a member of the Active Medical Staff of Boulder who has education, training/experience in the requested procedures or clinical management milieus, or an equivalent trainer, as deemed appropriate by the Joint Conference Committee. The trainer may only provide in-house training after the Joint Conference Committee has approved in-house training for a specific privilege or procedure.

Procedure:

1. CLINICIANS WILL BE REQUIRED TO:
   A. Complete in-house training forms including the inclusive dates of practice at Boulder Community Health. The clinician must be in good standing at the hospital, including but not limited to, no restrictions of practice privileges.
   B. Provide a written summary of the proposed program.
   C. Provide any additional documentation that may be deemed necessary to assure appropriate credentialing at Boulder Community Health.
   D. Comply with all hospital and medical staff rules and regulations and policies.
   E. Be trained by a member of the Active Medical Staff of Boulder.
   F. Practice under the direct training/supervision of the trainer.
   G. Conduct his/her practice at the hospital at all times within his or her training, qualifications and experience in a safe, competent and non-disruptive manner.
   H. Comply with requirements of the applicable state regulatory agency or licensing board.

2. THE TRAINER WILL:
   A. Advise patients of the trainee's status and obtain informed consent from the patient if they are to receive treatment of any kind by the clinician.
   B. Directly train/supervise the clinician to assure optimal patient safety at all times and ensure that the clinician will comply with all applicable rules, regulations, policies and procedures and practice in a safe, competent and non-disruptive manner in the hospital.
   C. Have been approved by the Hospital Governing Board for the privilege they wish To train.

3. CORRECTIVE ACTION
   A. If the Chief Executive Officer, in consultation with the trainer and the Chair of Credentials Committee or the Chair of the appropriate department, determines that the clinician has violated any rule, regulation, policy or procedures of the

hospital or Medical Staff, has engaged in conduct which is disruptive to the operation of the hospital or presents a likelihood of harm to the safety or welfare of patients, employees, Medical Staff members or other persons in the hospital, he shall immediately revoke the clinician's approval for in-house training at the hospital and shall notify the clinician and the trainer of such revocation.

B. The clinician and the trainer shall not be entitled to any procedural rights under the Bylaws of the Medical Staff, the Medical Staff Fair Hearing Plan or the Medical Staff Credentialing Manual based on the denial, restriction or revocation of the clinician's participation in an in-house training program at the hospital.

Policy Approved: Governing Board - 5/10/96; 9-05

COMPETENCY EVALUATIONS OF AHPs

Responsibility: Joint Conference Committee, Medical Staff of Boulder and Medical Staff Department

Purpose: To maintain the quality of care provided to patients at Boulder Community Health by assuring that Allied Health Professionals' qualifications and performance are evaluated in an appropriate and consistent manner with comparable practitioners employed by the hospital.

Policy: In order to ensure that the competencies of Consulting and Collaborating AHPs are judged against a single set of criteria, an evaluation process will be completed annually for those AHPs credentialed and/or contracted by, but not employed by BCH.

Procedure:

1. A Performance Evaluation tool/process, will be established each year, which is equivalent to the process and information gathered during an employee's annual SQR and competency assessment.

2. Annually, in a thirty-day period to be determined by the MSD, this process will be implemented and the reports will be forwarded to the Credentials Committee. Documentation of the evaluations will be maintained in each AHPs credentials file.

3. Should concerns be identified regarding the competency of an individual AHP, the Credentials Committee will refer the issue to the appropriate Department for further consideration/recommendation.

Policy Approved: Credentials Committee 4/06, MEC 5/06, Governing Board

IDENTIFICATION OF NEW APPLICANTS

Responsibility: Medical Staff Department

Purpose: To define a mechanism for ensuring that new applicants requesting approval are the same individuals identified in the credentialing documents.

Policy: A recent photo and a legible copy of a current government-issued picture ID must accompany a new applicant's request for approval. These documents will be used to verify that the person requesting approval is indeed the one identified in the submitted photo/government issued ID.

Procedure: A copy of the photo submitted by the applicant will be scanned and forwarded to past practices or training programs requesting verification that the applicants picture is indeed the person known to the reference.

In the event that the above information is not forthcoming, the government-issued ID will be used by Medical Staff Department personnel to positively identify the applicant.

Documentation of positive identification will be kept in the credentialing file.

Expedited Process for Granting Membership/Privileges

Responsibility: Medical Staff Department; Department Chairmen; Credentials Committee; MEC; JCC

1. **Policy:** This policy and procedure is made for rendering appointment, reappointment, and privileging decisions, **based on the judgment of the Joint Conference Committee,** through an expedited credentialing process without compromising the quality of the review. "Expedited credentialing" provides an expedited review and approval process if specific, pre-defined criteria are met. This process will reduce the volume of applications presented to the full Board to allow for adequate time to evaluate those candidates determined ineligible for the expedited process.

2. **Procedure:** Each application, its associated documentation and the information acquired during the credentialing and privileging process to determine eligibility for expedited review will be considered by the department chairman, credentials committee, medical executive committee.

   In order to be eligible for expedited approval, the following criteria must be met:

   2.1 The application is complete and accurate with all requested information returned. (A complete application is one in which not only is the application itself complete but all primary source verification and information required by the medical staff bylaws is complete as well).

   2.2 There are no **significant** discrepancies in information received and no **significant** negative or questionable information is received

   2.3 Medical staff/work history is unremarkable (i.e. no frequent moves or unexplained or alarming gaps).

   2.4 The applicant's request for clinical privileges is consistent with the medical staff's designation for applicant's specialty and his or her experience, training, and current competency; and all applicable privileging criteria are met.

   2.5 The applicant possesses a current, valid state license; professional liability insurance in limits specified by the medical staff; and federal/state narcotics certificate(s), if applicable.

   2.6 The applicant has indicated that he or she can safely and competently exercise the clinical privileges requested, with or without a reasonable accommodation.

   2.7 The applicant's history shows an ability to relate to others in a harmonious, collegial manner.

   2.8 At the time of renewal of privileges, documentation of activity in the hospital and/or verification from outside healthcare entities/peers sufficiently verifies current competence.

   2.9 At the time of renewal of privileges, the results of peer review activities and the quality improvement functions of the medical staff reveal no areas of concern.

   Each of the following criteria will be thoroughly evaluated on a case-by-case basis and may lead to ineligibility for expedited credentialing:

   A. The applicant's medical staff appointment, staff status, and/or clinical privileges have never been involuntarily resigned, denied, revoked, suspended, restricted, reduced, surrendered, or not renewed at another other healthcare facility.

B. The applicant has never withdrawn application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a decision was made by another healthcare facility's governing board or to avoid denial or termination of such.
C. No licenses; DEA or other controlled-substance authorizations; membership in local, state, or national professional societies; or board certification have ever been suspended, modified, terminated, or voluntarily or involuntarily surrendered.
D. The applicant has not been named as a defendant in a criminal action or been convicted of a crime.
E. There are no significant adverse findings reported by the National Practitioner Data Bank, Healthcare Practitioner Data Bank, Federation of State Medical Boards, the American Medical Association/American Osteopathic Association, or any other practitioner data base.
F. There are no past or pending malpractice actions, including clams lawsuits, arbitrations, settlements, awards, or judgments, that show an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
G. There are no proposed or actual exclusions and/or any pending investigations of the applicant from any healthcare program funded in whole in part by the federal government, including Medicare or Medicaid.

3. **Processing of Applications:** The Medical Staff Department receives and processes the application according to organization and medical staff policy.

If, an any point in the process below, any reviewer feels that the application does not meet criteria for expedited credentialing, the file will be processed and transmitted through the full review processes outlined in the medical staff bylaws.

3.1 The appropriate department chair or designee reviews the completed and verified application and forwards a report with findings and a recommendation to the credentials committee.
3.2 The credentials committee reviews the application at its next scheduled meeting and forwards its recommendation executive committee.
3.3 The medical executive committee reviews the application at its next scheduled meeting and forwards it recommendation to the joint conference committee of the board.
3.4 The Joint conference committee reviews and evaluates the qualifications and competence of the practitioner applying for appointment, reappointment, or renewal or modification of clinical privileges and renders its decision. A positive decision results in the appointment or privileges requested. The date of the committee's decision is the approval date. If the decision is adverse to an applicant, the matter will be referred back to the medical executive committee for further evaluation.
3.5 The joint conference committee will forward its actions to the full board at its next scheduled meeting.

Reference: **SECTION VI.** Processing Applications for Staff Appointment, 16-18.

Policy Approved: Governing Board 4/28/09
Revised: Governing Board 8/25/09

HEALTH SCREENING

BCH MEDICAL STAFF APPLICANT ____

Please Print

I understand that I am required to complete a health screening, which will include a urine drug test and that my application is not considered complete until the results have been received.

Date: ____________ Signature ____

INSTRUCTIONS

Prior to approval of your hospital appointment and/or privileges, you will need to be seen in BCH's Employee Health Department to complete a health screening (to include a urine drug test). Please use the following checklist to make sure your visit goes smoothly.

- ⇒ BCH's Employee Health is located in the basement of the Tebo building, 4715 Arapahoe.
- ⇒ Email Employee Health at employeehealth@bch.org to make an appointment, or call 303.415-7660. You will be asked to sign a consent form for the testing. You should plan to be in employee health for approximately 30-45 minutes.
- ⇒ Health records you have already completed.
- ⇒ A valid driver's license, State ID or passport is necessary to verify identity.
- ⇒ Be sure to identify yourself as an applicant for BCH Medical Staff or Allied Health Staff. This will ensure you are not billed for the service provided. (You might also want to bring a copy of this letter with you. However, the original must be submitted with your application).
- ⇒ Parking is located on the west side of the building.

Ref: Hospital Policy #21: Substance Abuse Policy