DELTA COUNTY MEMORIAL HOSPITAL

CREDENTIALING PROCEDURES MANUAL

TABLE OF CONTENTS

DELTA HEALTH

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DEFINITIONS

The following definitions apply to the provisions of this Credentialing Manual:

1. Wherever the term "Board" appears, it shall refer to the Board of Directors of Delta Health.

2. The term “Administrator” means the administrative position of the Medical Staff Coordinator, under the oversight and approval of the Hospital Administrator. All recommendations, actions and notices are by the authority and signature of the Hospital Administrator.

3. The term "**Provider**" shall mean a licensed, independent provider who is a doctor of medicine or osteopathy, dentist, podiatrist, AHP or other individual licensed or certified by the Colorado State Board of Health applying for or exercising clinical privileges or providing other diagnostic, therapeutic, teaching, or research services in the hospital.

4. The term "Physician" shall mean a doctor of medicine or a doctor of osteopathy fully licensed to practice medicine in Colorado.

5. “Clinical Privileges” means the rights granted to a provider to supply those diagnostic, therapeutic, medical, surgical, or dental services specifically delineated to him/her.

6. “Prerogative” means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions and limitations imposed in the Medical Staff Bylaws and in other hospital and medical staff policies.

7. “Special Notice” means written notification sent by Certified Mail, return receipt requested.

PART I. APPOINTMENT PROCEDURES

1.1 APPLICATION

Application for staff membership must be submitted by the applicant. The application must be in writing and on such form as designated by the Medical Executive Committee and approved by the Board. Prior to the application being submitted, the applicant will be provided a copy of, or access to a copy of, the Hospital Bylaws, the Medical Staff Bylaws and its accompanying policies, the Rules and Regulations of the staff and its services, and summaries of other hospital and staff policies and resolutions relating to clinical practice in the hospital.

1.2 APPLICATION REQUIREMENTS & CRITERIA FOR PRIVILEGES

Every applicant must furnish complete information concerning the following:

(a) A completed Colorado Health Care Professional Credentials Application Form, including all requirements listed in the general instructions.

(b) Postgraduate training, including the name of each institution, degree granted, program completed, dates attended, and names of providers responsible for the applicant's performance.

(c) Proof of 20 CME credits in the past two years. If applicant has not accumulated 20 CME credits in the past two years, must provide a documented plan to achieve 20 CME credits in the following year before their provisional status expires.

(d) All currently valid medical, dental, and other professional licensures or certifications, and Drug Enforcement Administration registration, with the date and number of each. If a new applicant has applied for a DEA but it is currently pending, they can submit a DEA Waiver form with their application. Applicant must designate, and provide the name(s) of, a DCMH provider who will cover prescriptive authority for applicant until their DEA is received. Administration will verify the DEA registration for the covering provider(s) and attach it to the DEA waiver.

(e) Specialty or sub-specialty board certification, recertification, and eligibility.

(f) Health impairments, if any, affecting the applicant's ability in terms of skill, attitude, or judgment to perform professional and medical staff duties fully; hospitalizations or other institutionalizations for significant health problems; including any continuing health problems requiring current therapy.

(g) Professional liability insurance coverage, information of malpractice claims history, and experience (suits and settlements made, concluded and pending), including the names of present and past insurance carriers in the last ten (10) years.

(h) The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment (by resignation or expiration) of: license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state, or national professional organizations; specialty or sub-specialty board certification or eligibility; faculty membership at any medical or other professional school; staff membership status, prerogatives or clinical privileges at any other hospital, clinic, or health care institution.

(i) Location of offices and addresses with whom the applicant is or was associated with and inclusive dates of such association; names and locations of any other hospital, clinic, or health care institution or organization where the applicant provides or provided clinical services with the inclusive dates of each affiliation.

(j) Service assignment, staff category, and specific clinical privileges requested.

(k) Any current felony criminal charges pending against the applicant and any past charges, including their resolution.

(l) Any Medicare or Medicaid exclusions or sanctions.

(m) Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity, and release provisions of the Medical Staff Bylaws and this Credentialing Procedures Manual.

Verification of the following will be done by the Medical Staff Coordinator, and confirmed by the Administrator, applicable Service Chair(s), Chief of Staff, and Board of Directors:

- American Medical Association (AMA) / American Osteopathic Association (AOiA)
- National Practitioner Data Bank (NPDB)
- Office of Inspector General (OIG)
- Colorado Licensure revocations or restrictions

1.3 REFERENCES

The application must include the names of three (3) individuals who have personal knowledge of the applicant's current clinical ability, ethical character, and ability to work cooperatively with others and who will provide specific written, substantive comments on these matters upon request from hospital or medical staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time and, at least one, must have had organizational responsibility for supervision of their performance (e.g., department chairman, service chief, training program director).

1.4 EFFECT OF APPLICATION

The applicant must sign the application and in so doing:

(a) Attests to the correctness and completeness of all information furnished;

(b) Signifies his willingness to appear for interviews in connection with his application;

(c) Agrees to abide by the terms of the bylaws, rules, regulations, policies and procedures, manuals of the Medical Staff and those of the hospital if granted membership and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or privileges are granted.

(d) Agrees to maintain an ethical practice and to provide appropriate professional coverage for his hospitalized patients.

(e) Authorizes and consents to hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence;

(f) Releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the applicant's competence, professional ethics, character, health status, and other qualifications for staff appointment and clinical privileges.

(g) Certifies that the applicant is able to meet the physical and mental requirements of the practice and privileges described and requested in the application.

For purposes of this Section, the term "hospital representative" includes the Board, its directors and committees; the Administrator or his designees; 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 applications; and any authorized representative of any of the foregoing.

1.5 PROCESSING THE APPLICATION

1.5-1 APPLICANT'S BURDEN

The applicant has the burden of producing adequate information for a proper evaluation of his/her experience, training, demonstrated ability, and health status, and of resolving any doubts about these or any of the qualifications required for staff membership or the requested staff category, service assignment, or clinical privileges, and of satisfying any reasonable requests for information or clarification (including health examinations) made by appropriate staff or board authorities.

1.5-2 VERIFICATION OF INFORMATION

The completed application is submitted to the Medical Staff Coordinator. The Medical Staff Coordinator collects or verifies the references, licensure, and other submitted qualifying evidence including clinical performance and promptly notifies the applicant of any problems in obtaining the information. Upon such notification, it is the applicant's obligation to obtain the required information. When collection and verification is accomplished, the Medical Staff Coordinator transmits the application and all supporting materials to the Chairman of each Service Committee in which the applicant seeks privileges and to the Chairman of the Medical Executive Committee.

The failure of an applicant to provide information which is free of 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 for credentialing, is cause for 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 may be automatically and immediately terminated. Rejection of an application or termination of membership or clinical privileges on the grounds stated in this paragraph shall not entitle the applicant to any procedural rights under the Fair Hearing Plan. If the information revealed as a result of any misrepresentation, misstatement, omission or inaccuracy on an application or subsequent submission of information indicates that the provider 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 action, one (1) year after the rejection or termination was enacted.

1.5-3 SERVICE ACTION

The chairman of each service committee in which the applicant seeks privileges reviews the application and its supporting documentation and forwards to the Medical Executive Committee a written report evaluating the evidence of the applicant's training, experience, and demonstrated ability. This report shall state the service committee chairman's recommendation as to approval or denial of, and any special limitations on, staff appointment, category of staff membership and prerogatives, service affiliation, and scope of clinical privileges. Any irregularities in the application, including, but not limited to, any misrepresentations, misstatements, omissions or inaccuracies in the application, any adverse information, or need for further information shall be noted in the report, even if the chairman is recommending approval of the application.

A service committee chairman may also, at his/her discretion, conduct an interview with the applicant. If a service committee chairman requires further information about an applicant, s/he may defer transmitting their report but their deferral time must not exceed 30 days. In case of a deferral, the applicable chairman must notify the applicant, the Chief of Staff, and the Administrator in writing of the deferral and the grounds.

1.5-4 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee (MEC), at its next regular meeting, reviews the application, the supporting documentation, the reports and recommendations from the service committee chairmen, based on objective evidence based process and any other relevant information available to it. The MEC defers action on the application or prepares a report with recommendations as to approval or denial of, or any special limitations on, staff appointment, category of staff membership and prerogatives, service affiliation, and scope of clinical privileges as based on the successful completion and verification of the requirements set forth in section 1.2 of this manual. Any irregularities in the application, including, but not limited to, any misrepresentations misstatements, omissions, or inaccuracies in the application, any adverse information, or need for further information shall be put in writing and brought to the attention of the Board of Directors, even if the Medical Executive Committee is recommending approval of the application.

The MEC also considers whether there is sufficient clinical performance information to accept recommendation determined by the clinical service committee to grant, limit or deny requested privileges and to forward to their recommendation to the Board of Directors for approval.

1.5-5 EFFECT OF MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION

(a) Deferral: Action by the MEC to defer the application for further consideration must be followed up within 30 days with subsequent recommendations as to approval or denial of, or any special limitations on, staff appointment, category of staff membership and prerogatives, service affiliation, and scope of clinical privileges. The Administrator promptly sends the applicant written notice of an action to defer.

(b) Favorable Recommendation: When the MEC's recommendation is favorable to the applicant in all respects, the Administrator promptly forwards it, together with all supporting documentation, to the Board. "All supporting documentation" means the application form and its accompanying information, the reports and recommendations of the service~~s~~ committees, MEC and dissenting views.

(c) Adverse Recommendation: When the MEC's recommendation is adverse to the applicant, the Administrator immediately so informs the applicant by special notice, and he is then entitled to the procedural rights as provided in the Fair Hearing Plan before the recommendation is presented to the Board. If the applicant elects a hearing, the findings and recommendations of the hearing panel will be presented to the Board along with the recommendations of the Medical Executive Committee. An "adverse recommendation" by the MEC is defined as a recommendation to deny appointment, requested staff category, requested service assignment, or to deny or restrict requested clinical privileges.

1.5-6 BOARD ACTION

(a) On Favorable Staff Recommendation: The Board may adopt or reject, in whole or in part, a favorable recommendation of the MEC or refer the recommendation back to the

MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made.

Favorable action by the Board is effective as its final decision.

(b) Without Benefit of MEC Recommendation: If, in its determination, the Board does not receive an MEC recommendation in timely fashion, it may, after notifying the MEC of its intent including a reasonable period of time for response, take action on its own initiative, employing the same type of information usually considered by the staff. Any favorable action is effective as its final decision.

(c) After Procedural Rights: In the case of an adverse MEC recommendation, the Board takes final action in the matter as provided in the Fair Hearing Plan.

(d) Adverse Board Action Defined: "Adverse action" by the Board means action to deny appointment, requested staff category, requested service assignment, or to deny or restrict requested privileges.

1.5-7 BASIS FOR RECOMMENDATIONS AND ACTIONS

The report of each individual or group required to act on an application must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Any dissenting views at any point in the process must also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

1.5-8 CONFLICT RESOLUTION

Whenever the Board determines that it will decide a matter contrary to the MEC's recommendation, the matter will be submitted to an Ad Hoc Committee, composed of, members of the Medical Staff appointed by the Chief of Staff and members of the Board of Directors appointed by the Chair person of the Board of Directors for review and recommendation before the Board makes its decision.

1.5-9 NOTICE OF FINAL DECISION

(a) Notice of the Board's final decision is given through the Administrator to the MEC, to the Chairman of each Service committee concerned, and to the applicant by U.S. Postal Service within 10 days of the Board of Director’s decision.

(b) A decision and notice to appoint includes:

i) the staff category to which the applicant is appointed;
ii) the service committee to which he is assigned;
iii) the clinical privileges s/he may exercise; and
iv) any special conditions attached to the appointment.

1.5-10 TIME PERIODS FOR PROCESSING

All individuals and groups required to act on an application for staff appointment must do so in a timely and good faith manner and, except for good cause, each application should be processed within the following time periods:

INDIVIDUAL/GROUP	TIME
(a) Administration	30 Days
(b) Service Committee Chair	30 Days
(c) Medical Executive Committee	Next Regular Meeting
(d) Board	Next Regular Meeting

These time periods are to be deemed guidelines and are not directives such as to create any rights for a provider to have an application processed within these precise periods. If the provisions of the Rules for Hearings are activated, the time requirements provided there govern the continued processing of the application.

1.5-11 WAITING LIST FOR DENIALS BASED ON NEED OR ABILITY TO ACCOMMODATE

When a final adverse decision has been made on an application for staff membership, service affiliation, or particular clinical privileges on the basis of what is reasonably projected to be a temporary lack of hospital or community need, inability of the hospital to provide adequate facilities or supportive services, or inadequate patient load, the application shall, upon written request by the applicant to the Administrator, be kept in a pending status for the next succeeding 2 years. If during this period, the hospital finds it possible to accept staff applications for which the applicant is eligible, and there is no obligation to applicants with prior pending status, the Administrator promptly so informs him by special notice. Within 30 days of receipt of such notice, the applicant must provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his original application. Thereafter, the procedure provided in Section 1.5 of this manual applies.

1.5-12 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment, staff category, service assignment, or clinical privileges is not eligible to reapply to the Medical Staff or for the denied category, service, or privileges for a period of one (1) year. Any such reapplication is processed as an initial application, and the applicant must submit such additional information as the Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

1.15-13 PROVISIONAL APPOINTMENT PRACTICE EVALUATION MS 4.40

The Provisional Practice Evaluation has been defined by the Medical Staff as a Focused Professional Practice Evaluation (FPPE). Each Clinical Service Committee has developed criteria to evaluate the provider's performance, which includes outlining the number and types of procedures/admissions, clinical information based on specialty, to be reviewed and the timeframe. See Part V. of this Credentialing Manual for further details.

The Administrator evaluates the resources, equipment, supporting personnel, space and financial obligations regarding this physician prior to forwarding this information on to the service representative, Medical Executive Committee and the Board of Directors.

PART II. REAPPOINTMENT PROCEDURES

2.1 INFORMATION COLLECTION AND VERIFICATION

2.1-1 FROM STAFF MEMBER

Approximately four months prior to the date of expiration of a medical staff member's appointment, the Administrator notifies him/her of the date of expiration. Preferably ninety days**,** at least sixty (60) days prior to this date, the member furnishes, in writing:

(a) complete information to update his/her file on the items listed in Section 1.2 of this manual;

(b) continuing training and education external to the hospital during the preceding period;

(c) specific request for the clinical privileges sought on reappointment, with any basis for changes;

(d) requests for changes in staff category or service assignments.

(e) certification that the provider remains capable of meeting the physical and mental requirements of the practice and privileges described and requested in the Application for Reappointment.

Failure, without good cause, to provide this information is deemed a voluntary resignation from the staff and results in automatic termination of membership at the expiration of the current term unless explicitly extended for not more than two 30- day periods by action of the MEC. A provider whose membership is so terminated is entitled to the procedural rights provided in the Rules for Hearings for the sole purpose of determining the issue of good cause. The Administrator verifies this additional information and notifies the staff member of any information inadequacies or verification problems. The staff member then has the burden of producing adequate information and resolving any doubts about the data.

2.1-2 FROM INTERNAL SOURCES

The Administrator collects for each staff member's credentials file all relevant information regarding the individual's professional and collegial activities, performance, and conduct in this hospital. Such information includes, without limitation:

(a) patterns of care as demonstrated in the findings of quality assurance activities;

(b) participation in relevant internal teaching and continuing education activities;

(c) attendance at medical staff, hospital CME events and service meetings;

(d) service on medical staff, service, and hospital committees if applicable;

(e) compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and staff.

(f) Ongoing Professional Practice Evaluation (OPPE) of competencies based on clinical performance as determined by the respective clinical service committees which may include but is not limited to: numbers of admits, blood usage, clinical outcomes and

specialty specific case monitoring. The evaluation of clinical performance is conducted twice annually and reviewed by the MEC to identify any concerns that need to be addressed.

2.2 SERVICE ACTION

Each chairman of a Service Committee in which the staff member requests or has exercised privileges reviews the member's file and forwards to the Medical Executive Committee a written report, including a statement as to whether or not he knows of, or has observed or been informed of any conduct which indicates significant present or potential physical or behavioral problems affecting the provider's ability to perform professional and medical staff duties appropriately and with recommendations for reappointment or non-reappointment and for staff category, service assignment, and clinical privileges.

2.3 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee (MEC) reviews the member's file, the service reports, and any other relevant information available to it and defers action on the reappointment or prepares a written report with recommendations for reappointment or non-appointment and for staff category, service assignment, and clinical privileges.

2.4 FINAL PROCESSING AND BOARD ACTION

Final processing of reappointments follows the procedure set forth in Sections 1.5-5, 1.5-6 (a) through (c), 1.5-8, 1.5-9, 1.5-11, and 1.5-12. For purposes of reappointment, an "adverse recommendation" by the MEC or an "adverse action" by the Board as used in those Sections means a recommendation or action to deny reappointment; to deny a requested change in, or to change without the staff member's consent, his/her staff category, service assignment; or to deny or restrict requested clinical privileges. The terms "applicant" and "appointment" as used in those Sections shall be read respectively, as "staff member" and "reappointment".

2.5 BASIS FOR RECOMMENDATIONS AND ACTION

The report of each individual or group required to act on a reappointment shall state the reasons for each recommendation made or action taken, with specific reference to the staff member's credentials file and all other documentation considered. Any dissenting views at any point in the process must also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

2.6 TIME PERIODS FOR PROCESSING

Transmittal of the notice to a staff member and his/her providing updated information is to be carried out in accordance with Section 2.1-1 of this manual. Thereafter and except for good cause, all persons and groups required to act must complete such action so that all reappointment reports and recommendations are transmitted to the MEC and in turn to the Board prior to the expiration date of staff membership of the member whose reappointment is being processed.

The time periods specified are to guide the acting parties in accomplishing their tasks. If reappointment processing has not been completed by an appointment expiration date, through no fault of the staff member, the member maintains his/her current membership status and clinical privileges until the time that processing is completed, unless corrective action is taken with respect to all or any part thereof. If the delay is attributable to the provider's failure to

provide information required by Section 2.1-1, his/her staff membership terminates on the expiration date as provided in Section 2.1-1 unless explicitly extended as provided therein. An appointment extension is not to be deemed to create a right of automatic reappointment for the coming term.

2.7 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category, service assignment, or clinical privileges by submitting a written application to the Administrator. A modification application is processed in the same manner as a reappointment. The criteria for granting a new privilege(s) will include review of provider professional practice evaluation data that is collected and assessed on an ongoing basis.

PART III. SYSTEMS AND PROCEDURES FOR DELINEATING CLINICAL PRIVILEGES

3.1 CATEGORIES OF CLINICAL PRIVILEGES

Clinical privileges at this hospital will be granted in the categories listed below to providers demonstrating specific qualifications for the exercise of privileges in those categories.

3.2 CATEGORY III PRIVILEGES

Physicians with privileges in these procedures are expected to have training and/or experience and/or competence on a level commensurate with that provided by special training in the procedure. Such physicians may act as consultants to others and may in turn be expected to request consultation when:

a. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;

b. Unexpected complications arise which are outside this level of competence; and

c. Specialized treatment or procedures beyond the level of expertise are contemplated.

3.3 CATEGORY II PRIVILEGES

Physicians with these privileges are expected to have training and/or experience and/or competence at a level which would qualify them to perform routine procedures to include general care and management of common complications and medical problems. Such physicians would be expected to request consultation from a physician with Category III privileges if:

a. Diagnosis and/or management remain in doubt, especially in the presence of life threatening illness;

b. Unexpected complications arise which are outside this level of competence; and

c. Specialized or unusual treatment or procedures are contemplated.

3.4 CATEGORY I PRIVILEGES

Physicians with these privileges may render emergency care of the most preliminary nature. Further management must then be provided by an appropriately qualified physician.

3.5 CONSULTATION

There may be attached to any grant of privileges in any Category, in addition to requirements for consultation in specific circumstances provided for in the bylaws, or in the rules, regulations and policies of the staff, any of its clinical units or the hospital, special requirements for consultation as a condition to the exercise of particular privileges.

3.6 SERVICE COMMITTEE RESPONSIBILITY

To implement this method for granting clinical privileges, each Service Committee must define, in writing, the various categories for the procedures, conditions, and problems that fall within its clinical area. These definitions must be approved by the Medical Executive Committee and by the Board, must be periodically reviewed and revised, and must form the basis for Service Committee clinical privileges recommendations.

3.7 PROCEDURE FOR DELINEATING PRIVILEGES

3.7-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant or staff member. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappraisals.

3.7-2 PROCESSING REQUESTS

All requests for clinical privileges will be processed according to the procedures outlined in Parts I and II of this manual, as applicable.

PART IV. REVIEW, CONCLUSION AND EXTENSION OF PROVISIONAL PERIOD

4.1 SUCCESSFUL CONCLUSION

4.1-1 STATEMENTS REQUIRED

No earlier than six months or no later than one year after appointment to the staff or the granting of increased privileges, a provider must submit to the Medical Executive Committee a request for a declaration that all or any part of his/her provisional period is successfully concluded. A new appointee's request must be accompanied by one or more signed statements described in Sections 4.1-1 (a) and (b). The statements that must be furnished are:

(a) From the chairman of the Service Committee in which his/her appointment was made attesting that by his/her performance the provider has demonstrated his/her qualifications for staff membership and for his/her staff category, that he/she has not abused his/her prerogatives, and that he/she has discharged his/her membership obligations; and

(b) From the chairman of each Service Committee in which he/she was granted initial or increased clinical privileges that he/she has satisfactorily demonstrated his/her ability to exercise those privileges.

4.1-2 ACTION REQUIRED

The Medical Executive Committee considers the requests and statement(s) furnished to it and defers action on the request but for no more than 30 days or prepares a written report with recommendations and supporting documentation. Final processing follows the procedures set forth in the appointment process. For purposes of concluding the provisional period, an "adverse recommendation" by the MEC or an "adverse action" by the Board as used in the appointment process means a recommendation or action to change, without the staff member's consent, his/her Service assignment; to reduce staff category assignment without his/her consent; or to deny or restrict requested clinical privileges. The terms "applicant" and "appointment" as used in those Sections shall be read, respectively, as "staff member" and "conclusion of the provisional period."

4.2 PROCEDURAL RIGHTS

Whenever a provisional period, including any period of extension, expires without favorable conclusion for the provider or whenever an extension is denied, the Administrator will provide him/her with special notice of the adverse result and of his entitlement to the procedural rights provided in the Medical Staff Bylaws.

PART V. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

5.1 DEFINITION OF FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

A Focused Professional Practice Evaluation (FPPE) is a time-limited period during which Delta Health evaluates a Practitioner's clinical performance and/or professionalism. Clinical performance includes but is not limited to (a) quality of patient care, (b) medical and clinical knowledge/skill, (c) patient outcomes, and (d) patient safety. Professionalism includes but is not limited to compliance with the Culture of Safe Behavior Policy, and interpersonal and communication skills.

5.2 USE OF THE FPPE

5.2-1 Initial Privileges: A FPPE is required for all new applicants and should be completed within 12 months of initiation of clinical activity. This time may be extended at the discretion of the Committee Chair if documented extenuating circumstances exist. The scope of the FPPE, the level of proctoring required, and the number of cases or charts to be reviewed will be determined by the respective Committees.

5.2-2 Locum Tenens: Locum tenens practitioners are not subject to this Part V so long as their locum tenens agreement contains a provision allowing Delta Health to cancel their assignment for no-cause.

5.2-3 New Privilege(s) for Existing Members: A FPPE is required when an existing member of the medical staff applies for privileges significantly different from her/his current practice, and should begin with the applicant's first performance of the newly requested privilege. The scope of the FPPE, the level of proctoring required, the number of cases or charts to be reviewed, and

the duration of the FPPE will be determined by the respective Committee. In the event the member does not have adequate case volume to complete the FPPE in the required timeframe of the FPPE, the FPPE will be extended until volume is sufficient, not to exceed 12 months from the start date of the FPPE, unless an extension is requested in writing by the practitioner and approved by the Medical Executive Committee. The practitioner's existing privileges remain in good standing during the pendency of the FPPE.

5.2-4 FPPE Required Following Peer Review: When a FPPE is recommended as a result of peer review, the respective Committee Chair will propose the scope of the FPPE, the level of proctoring required, the number of cases required, and the duration of the FPPE based upon the individual circumstances at issue. The proposed FPPE must then be approved by the Peer Review Committee or the Medical Executive Committee prior to implementation.

5.2-5 Concerns Regarding Provision of Care or Unprofessional Behavior: The FPPE process may be implemented by the Medical Executive Committee when concerns arise regarding a member's provision of safe, quality patient care or concerns regarding unprofessionalism. Such concerns may surface during review of a member's Ongoing Professional Practice Evaluation (OPPE) data, through identified trends by the staff, or when the issue is otherwise brought to the Medical Executive Committee's attention. The FPPE should not be imposed as a form of discipline, but rather to assess competency and/or professionalism. A FPPE should be imposed only for such period or number of cases as is reasonably necessary to enable the desired assessment. If disciplinary or corrective action is warranted, the process delineated in Article VI of the Medical Staff Bylaws should be followed.

5.3 FPPE PROCEDURE

5.3-1 Each Committee Chair shall be responsible for overseeing the FPPE process for all applicants or staff members assigned to her/his Committee.

5.3-2 During a FPPE, the practitioner must demonstrate professionalism and the clinical competence to exercise the privileges at issue.

5.3-3 Information for a FPPE may be derived from any combination of the following sources:

(a) Proctoring. Clinical proctoring is an objective evaluation of a practitioner's clinical competence by a proctor who has documented expertise for specific procedures. Proctors must be a member in good standing on the Delta Health medical staff, must have unrestricted privileges to perform any procedure to be observed and/or evaluated, and shall be mutually agreed upon between the Committee Chair and the physician being evaluated. When proctoring is required, the respective Committee will determine the type of proctoring required, the number of cases, admissions or procedures to be proctored, and the duration of proctoring. The proctor is expected to make reasonable accommodation to be available for cases that require direct or indirect proctoring. The proctor must complete all documentation accurately and promptly.

- **Direct**: a proctor must be in attendance in the room while the care, activity or procedure is provided or performed. This is usually used for invasive procedures so that the medical staff has first-hand knowledge necessary to satisfy itself that the physician is competent.

- **Indirect**: a proctor is present in the area and immediately available. It does not mean the proctor must be present in the room while the procedure is performed.

(b) Chart Review.

- **Prospective Review**: a review by the evaluator of either the patient's chart or the patient personally before treatment. This type of review may be used if the indications for a particular procedure are difficult to determine or if the procedure is particularly risky.

- **Retrospective Review:** a retrospective review of patient charts by the evaluator. The evaluator's presence is not required while the care activity is being performed. This level of supervision is not used for proctoring procedures but may be used to assess competency in management of care situations.

(c) Discussion with other individuals involved in the care of each case or chart reviewed (e.g. consulting physician, assistants, nursing staff, or administrative personnel).

(d) When available, review of the member's Ongoing Professional Practice Evaluations (OPPEs).

(e) Simulation.

(f) External peer review. An external peer review may be initiated in the following circumstances:

- The Committee Chair or Credentialing Committee determines that the expertise necessary to appropriately conduct the FPPE does not exist within the Delta Health medical staff; and/or

- The Committee Chair or Credentialing Committee believe that an external review would be more objective and in the best interest of the practitioner and Delta Health.

(g) Review of malpractice claims.

5.3-4 Temporary Privileges Pending Proctoring. Only in situations where proctoring is a requirement of the FPPE and the practitioner meets all qualifications and requirements of the FPPE except the number of proctored cases required, temporary privileges may be granted at the discretion of the Credentialing Committee.

5.3-5 If a question arises as to the practitioner's competence to exercise the affected privileges and there is concern about imminent threat to patient safety, at any time during the evaluation, there may be a precautionary suspension of privilege(s) as identified in the Credentialing Manual and/or Medical Staff Bylaws.

5.3-6 The results of the FPPE shall be reviewed by the appropriate Department Committee in executive session. The FPPE shall then be submitted to the Medical Staff Office and reviewed by the Credentialing Committee in executive session for either final approval or a determination that further action is necessary.

5.3-7 A FPPE shall be deemed successfully completed when the practitioner completes the required criteria within the time frame established by the respective Committee, and his/her Department Committee and the Credentialing Committee have determined that the member's professional performance met the standard of care or other applicable requirements for the privileges at issue.

5.3-8 If a practitioner fails to perform satisfactorily or fails to complete the FPPE, she/he may voluntarily withdraw the application for privileges or she/he may contest the results of the FPPE in writing and request a formal review of the FPPE by the Medical Executive Committee. The formal review shall be conducted in accordance with the procedures delineated in Article VII of the Medical Staff Bylaws. If there is a threat to patient safety by continuing existing privileges during a contested review of the FPPE results, suspension of existing privilege(s) may occur as delineated in the Credentialing Manual and/or Medical Staff Bylaws.

5.4 RESPONSIBILITIES OF THE FPPE EVALUATOR/PROCTOR

All provisions of this Section apply to any FPPE evaluators and/or proctors.

5.4-1 All FPPE evaluators must be in good standing on the Delta Health medical staff and must have unrestricted privileges in the practice areas to be evaluated. The role of evaluator/proctor is a critical function of the privileging process and therefore accepting that responsibility is a criterion for medical staff membership at Delta Health.

5.4-2 The evaluator is not a mentor or a consultant; the evaluator is an agent of Delta Health. The evaluator should nonetheless render emergency medical care to any patient experiencing medical complications arising from the care provided by the practitioner being evaluated.

5.4-3 The evaluator must complete all required documentation associated with the respective FPPE, and must complete all requisite FPPE forms accurately and promptly.

5.4-5 The evaluator shall not bill any patient for her/his time or service as an evaluator.

5.4-5 If at any time during the evaluation period the evaluator has concerns about the practitioner’s competency to perform specific clinical privileges or care related to a specific patient, the evaluator shall promptly notify the Committee Chair.

5.4-6 The evaluation shall ensure the confidentiality of all FPPE results and forms. The evaluator will submit completed FPPE forms to the Medical Staff Office.

PART VI. CORRECTIVE ACTION PROCEDURES

6.1 ROUTINE CORRECTIVE ACTION

6.1-1 REQUESTS AND NOTICES

All requests for corrective action must be in writing submitted to the Medical Executive Committee (MEC) and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chief of Staff promptly notifies the Administrator and involved physician in writing of all requests.

6.1-2 INVESTIGATION

After deliberation, the MEC may either act on the request or direct that investigation concerning the grounds for the corrective action request be undertaken. The MEC may conduct such investigation itself or may assign this task to a Medical Staff Officer, Service, standing or ad hoc committee, or other organizational component. This investigative process is not a "hearing" as that term is used in the Fair Hearing Plan. It may include a consultation with the provider involved and with the individual or group making the request and with other individuals who may

have knowledge of the events involved. If the investigation is accomplished by a group or individual other than the MEC, that group or individual must forward a written report of the investigation to the MEC as soon as is practicable after the assignment to investigate has been made. The MEC may at any time within its discretion, and shall at the request of the Board, terminate the investigative process and proceed with action as provided below.

6.1-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within 60 days after receipt of the request for corrective action unless deferred, the MEC acts upon such request. Its action may include, without limitation:

(a) Recommending rejection of the request for corrective action.

(b) Recommending a warning or a formal letter of reprimand.

(c) Recommending a probationary period with retrospective review of cases but without special requirements of prior to concurrent consultation or direct supervision.

(d) Recommending suspension of membership prerogatives that do not affect clinical privileges.

(e) Recommending individual requirements of consultation or supervision.

(f) Recommending reduction, suspension or revocation of clinical privileges.

(g) Recommending reduction of staff category or suspension or limitation of any prerogatives directly related to the provider’s provision of patient care.

(h) Recommending suspension or revocation of staff membership.

6.1-4 DEFERRAL

If additional time is needed to complete the investigative process, the MEC may defer action on the request but only upon written consent of the affected practitioner. A subsequent recommendation for any one or more of the actions provided above must be made within the time specified in the consent, and if no time is specified, then within 30 days of the deferral.

6.1-5 PROCEDURAL RIGHTS

A MEC Section 6.1-3 recommendation for individual consultation, decreased privileges, reduced category, diminished or suspended patient care prerogatives, or suspended or revoked membership is deemed adverse and entitles the practitioner to the procedural rights contained in the Medical Staff Bylaws.

6.1-6 OTHER ACTION

(a) A MEC Section 6.1-3 recommendation for rejection, warning/reprimand, probation with retrospective monitoring, or diminished prerogatives that do not affect clinical privileges is not deemed "adverse" and is transmitted to the Board together with all supporting documentation. Thereafter, the procedure in Section 1.5-7 (a) of this manual is applicable. However, if the Board's initial action on any such recommendation represents a substantive change from the MEC's recommendations, the procedure at

Section 1.5-9 is applicable. A "favorable recommendation" as used in Section 1.5-7 (a) is any recommended action other than those in Section 6.1-5.

(b) If, in the Board's determination, the MEC fails to act in timely fashion in processing and recommending action on a request for corrective action, the procedure to be followed is as provided in Section 1.5-6 (b).

6.2 SUMMARY SUSPENSION

6.2-1 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as possible, but in any event within 5 days, after a summary suspension is imposed, the MEC convenes to review and consider the action taken. The MEC may recommend modification, continuation or termination of the terms of the suspension.

6.2-2 PROCEDURAL RIGHTS

Unless the MEC recommends immediate termination or modification of the suspension to one of the lesser sanctions provided for in Section 5.1-3 (a) through (d), the practitioner is entitled to the procedural rights contained in the Fair Hearing Plan.

6.2-3 OTHER ACTION

A MEC recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights is transmitted immediately, together with all supporting documentation, to the Board, and the procedure in Section 5.1-6 is followed. The terms of the summary suspension as originally imposed remain in effect pending a final decision by the Board, as applicable.

6.3 AUTOMATIC SUSPENSION

6.3-1 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable (a) after a practitioner's license is suspended, restricted or placed on probation, or (b) after his controlled substances number is revoked, restricted or placed on probation, the MEC convenes to review and consider the facts under which such action was taken. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation, including limitation of prerogatives. Thereafter, the procedure in Section 5.1-5 or 5.1-6, as applicable, is followed.

6.3-2 MEDICAL RECORDS COMPLETION

All medical records must be completed within 30 days.

A record is considered "complete" when the contents required by the Staff rules and regulations are assembled and authenticated and all final diagnoses and complications are recorded without the use of unapproved symbols or abbreviations. Justified reasons for delay in completing records include, without limitation:

(a) The provider is ill or otherwise unavailable for a period of time due to circumstances beyond their control, or if within their control, then completion of the records prior to their unavailability was not reasonably possible for reasons beyond their control**,** or

(b) The provider is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis, or

(c) The provider has dictated reports and is waiting for hospital personnel to transcribe them.

6.3-4 PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance in not less than the minimum amount, if any, as determined by resolution of the Board after consultation with the Medical Executive Committee, evidenced by a certificate of coverage from a licensed insurance company.

PART VII. LEAVE OF ABSENCE

7.1 LEAVE STATUS

A staff member may obtain a voluntary leave of absence by giving written notice to the Chief of Staff for transmittal to the applicable service committee chairman and the Administrator. The notice must state the approximate period of time of the leave, which may not exceed two years, except for military service. During the period of the leave, the staff member's clinical privileges, prerogatives, and responsibilities are suspended.

7.2 TERMINATION OF LEAVE

The staff member must, at least 45 days prior to the termination of the leave, or may at any earlier time, request reinstatement by sending a written notice to the Medical Executive Committee (MEC). The staff member must submit a written summary of relevant activities during the leave if the MEC or the Board of Directors so requests. The MEC makes a recommendation to the Board of Directors concerning reinstatement, and the procedures in Sections 1.5-5, 1.5-6, 1.5-8, 1.5-9, 1.5-11, and 1.5-12, as applicable, are followed.

PART VIII. PRESCRIBING OF CONTROLLED SUBSTANCES BY ALLIED HEALTH PROFESSIONALS

8.1 No Allied Health Professional (AHP), as defined in the Medical Staff Bylaws or as attached hereto, authorized to exercise privileges at Delta County Memorial Hospital, may prescribe controlled substances to patients of the Hospital unless he or she possesses and has provided to the Administrator a copy of his or her current, valid DEA Certificate and have an active Colorado RXN license. If a new AHP provider's RXN license is provisional, provider must provide a copy of their Articulated Plan attested to the Colorado Medical Board, including the name of the precepting nurse practitioner or physician with prescriptive authority.

PART IX. PROVIDERS OFFERING CONTRACTUAL PROFESSIONAL SERVICES

9.1 In recognition of the hospital's policy that certain hospital facilities will be used on an exclusive basis in accordance with contracts between the hospital and qualified providers, such that other staff members must, except in emergency or life threatening circumstances, adhere to this exclusivity policy in arranging for the care of their patients, applications for initial appointment or for clinical privileges related to those hospital facilities and services specified in Section 8.2 will

not be accepted for processing unless submitted in accordance with an existing or proposed contract with the hospital.

9.2 QUALIFICATIONS

A provider who is or who will be providing specified professional services pursuant to a contract with the hospital must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of his/her membership category as any other applicant or staff member.

For the Purposes of Teleradiology: A practitioner who is or who will be providing specified professional services pursuant to a contract with the hospital would not be required to go thru the full credentialing process *IF* the contracted Teleradiology Service is a JCAHO accredited organization. Only primary source verification would be required on each of these providers.

9.3 EFFECT OF STAFF MEMBERSHIP TERMINATION

Because practice at the hospital is always contingent upon continued staff membership and is also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use hospital facilities is automatically terminated when staff membership expires or is terminated. Similarly, the extent of his/her clinical privileges is automatically limited to the extent that pertinent clinical privileges are diminished.

9.4 EFFECT OF CONTRACT EXPIRATION OR TERMINATION

(a) The effect of expiration or other termination of a contract upon a practitioner's staff membership status and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital.

(b) If the contract is silent on the matter or if there is no written contract, then contract expiration or other termination alone will not affect the practitioner's staff membership status or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which exclusive contractual arrangements have been made.

PART X. AMENDMENT

10.1 AMENDMENT

This Credentialing Procedures Manual may be amended or repealed, in whole or in part, by one of the following mechanisms:

(a) A recommendation from the Medical Executive Committee (MEC) to and adopted by the Board; or

(b) A resolution of the Board taken on its own initiative after notice to the MEC of its intent, including a reasonable period of time for response.

10.2 RESPONSIBILITIES AND AUTHORITY

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 and the circumstances under which the Board may resort to its own initiative in accomplishing those functions apply as well to the formulation, adoption, and amendment of this Credentialing Procedures Manual.

REVIEWED AND APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE on Nov 09, 2022.

Jarred Freese, M.D., Chief of Staff
Chairman, Medical Executive Committee

APPROVED BY THE BOARD OF DIRECTORS on Apr 17, 2023.

Jean Ceriani, President
Board of Directors

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