CREDENTIALS AND HEARING AND APPELLATE REVIEW POLICY AND PROCEDURE MANUAL

SLV REGIONAL MEDICAL CENTER

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ARTICLE I: PURPOSE AND USE OF MEDICAL STAFF DOCUMENTS

1.1 **Purpose** - The Medical Staff Documents, as defined in the Bylaws of the Medical Staff, are intended to establish guidelines for evaluation of Practitioners applying for appointment or reappointment to the Hospital's Medical Staff and/or Clinical Privileges, utilization review and quality assessment, corrective action, hearing and appellate review, medical staff organization and functions and accountability to the Hospital's Board. Nothing in these Bylaws is intended or shall be deemed to exercise control, supervision or direction over the provision of medical services in the Hospital by Practitioners who have been granted Medical Staff appointment and/or Clinical Privileges by the Board. Furthermore, these Medical Staff Documents are not intended to delineate specific medical practice or standards, but only relate to functions of the Hospital and its Medical Staff.

Generally, this Credentials Manual is intended to establish guidelines for the conduct of and processes relating to Practitioners who have applied for or been granted Medical Staff appointment and/or Clinical Privileges by the Board. This Credentials Manual is intended to establish guidelines for evaluation of Practitioners applying for appointment or reappointment to the Hospital's Medical Staff and/or Clinical Privileges, utilization review and quality improvement activities, corrective action, hearing and appellate review processes, accountability to and communication with the Hospital's Board.

It is intended that the processes and actions outlined and authorized in this Credentials Manual are taken in the course of professional review and constitute professional review action. It is also intended that the professional review bodies, participants and witnesses in the professional review processes outlined in this Credentials Manual and all professional review records be covered by the immunities and protections available under applicable state and federal law.

1.2 **Additional Rules** - The Medical Staff Documents are intended to inform members of the Hospital's Medical Staff of the policies, procedures, rules, regulations, guidelines and requirements which apply to them. There may be additional policies that apply to such Medical Staff appointees. It is each Medical Staff appointee's sole responsibility to obtain, read, understand and abide by the Medical Staff Documents and additional policies.

1.3 **Use - The Medical Staff Documents and other policies are unilateral expressions of the current requirements of the Hospital relating to applicants and members of the Medical Staff and are subject to change at any time. They do not constitute a contract of any kind whatsoever and any Practitioner who intends that they, or any of them should constitute a contract must first notify the Hospital and obtain the written consent of the Board. The Medical Staff Documents and other policies shall be interpreted, applied and enforced within the sole discretion of the Hospital or those individuals delegated responsibility for interpretation, application or enforcement.**

1.4 **Definitions** - Terms not otherwise defined herein are used as defined in the Bylaws of the Medical Staff.

ARTICLE II: PRE-APPLICATION POLICY

2.1 As a general policy, the Hospital permits application to the Medical Staff by licensed medical and osteopathic physicians and dentists. Practitioners who diagnose or treat patients via telemedicine link to the Hospital are subject to the credentialing and privileging processes of the Hospital and the organization that provides the telemedicine service.

Other health care professionals, including, but not limited to employees of appointees to the Medical Staff and AHPs who wish to provide specified services to patients of the Hospital on an inpatient or outpatient basis, may be permitted to apply to provide specified services pursuant to Article IV, Section 4.6 of the Bylaws. Non-Practitioner Hospital employees are not required to apply for and be granted Clinical Privileges or specified services to provide services to patients of the Hospital.

Exceptions to the policy may be made only by the Board.

2.2 It is the general policy of the Hospital to provide applications for appointment to the Medical Staff, upon request, to individuals who are able to:

2.2-1 Demonstrate that they are an M.D., D.O., D.D.S., or D.M.D., or the acceptable equivalent with a valid license in good standing to practice in the State of Colorado or that they are exempt from Colorado licensure requirements;

2.2-2 Demonstrate that they have obtained and will maintain professional liability insurance in such amounts required by the Hospital or state or federal law, whichever is highest, but in no event in an amount less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate, or are otherwise exempt from those insurance requirements under the following exceptions: Practitioners with Honorary or Consulting membership on the Medical Staff and Practitioners on leaves of absence are not covered by this mandatory professional liability insurance requirement.

2.2-3 Demonstrate that they have successfully completed a residency program approved by the ACGME or the AOA or other acceptable training or educational program, as applicable and/or be board eligible in their specialty ;

2.2-4 Demonstrate that they will provide services at the Hospital that are determined to be appropriate and to meet the needs and objectives of the Hospital in providing patient care services to the patients in its service area;

2.2-5 Represent that he/she is not now and never has been the subject of any actual or proposed exclusion from participation in any government sponsored health care program; and,

2.2-6 Provide such additional information as the Hospital or its Medical Staff may request.

2.3 Upon receipt of a completed application request form, the CEO will verify its contents and will, if the requirements of Section 2.2 are met, provide a response to the requesting individual that may or may not include an application. Such response shall be provided after verification and review of the pre-application is complete. In the event the requirements of Section 2.2 are not met, the potential applicant will be notified.

2.4 A determination not to extend an invitation for appointment shall not constitute an adverse action and shall not entitle the potential applicant who is the subject of that determination to any hearing, appellate review, or other rights under the Medical Staff Documents. The decision not to extend such an invitation shall not be a matter of peer review, but rather shall be a business, administrative decision, which shall not be reportable to the National Practitioner Data Bank or any licensing agency.

ARTICLE III: INITIAL APPOINTMENT

STAFF APPOINTMENT SHALL BE FOR A PERIOD NOT TO EXCEED ONE (1) YEAR-PROVISIONAL

3.1 If a potential applicant is given an Application for Staff appointment, it is to be submitted to the Medical Staff Office. The application must be typed or legibly written on any application now or hereafter required by state legislation. Prior to the application being submitted, the applicant will have access to the Medical Staff Documents and Hospital bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements. It is the applicant's burden to obtain, read and understand these documents.

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

3.2-1 Signifies his/her willingness to appear for interviews in regard to his/her application, if requested to do so at any stage of the application process. An applicant does not have a right to an interview;

3.2-2 Authorizes Representatives to consult with others who have been associated with him/her and/or who have information bearing on his/her competence and qualifications;

3.2-3 Consents to Representatives' inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the Clinical Privileges he/she requests, of his/her physical and mental health status and of his/her professional and ethical qualifications;

3.2-4 Releases from any and all liability Representatives for their acts, conduct or omissions performed in connection with evaluation of him/her or his/her credentials;

3.2-5 Releases from any and all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Representatives concerning his/her competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Staff appointment and Clinical Privileges;

3.2-6 Authorizes and consents to 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/her, and releases representatives from any and all liability for so doing. Authorizes and consents to the Hospital's exchange of information as outlined in the Medical Staff Documents;

3.2-7 Signifies that he/she has read and understands the current bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff and agrees to abide by their provisions and any amendments thereto, in regard to his/her application and appointment, if applicable, to the Medical Staff; and

3.2-8 Agrees to provide and update the information requested on the original application and subsequent applications for reappointment or reinstatement and privilege request forms, and to do so immediately upon the occurrence of any event which would result in a change in the information provided on the most current application form and to provide all information requested by the Hospital or its Medical Staff. For purposes of this Section 3.2-8 "immediately" means within seven (7) days of the change in information. Notification of a change in such information and any and all information relating thereto shall be provided in writing to the Medical Staff office. Information that must be provided and updated includes voluntary relinquishment of Medical Staff appointment or Clinical Privileges at any health care facility or other provider organization, voluntary or involuntary limitation, denial, reduction, suspension or termination of appointment, reappointment or Clinical Privileges, corrective action, investigation for potential corrective action, letters of reprimand or admonition at another health care facility or other provider organization, liability settlements and all judgments, any and all licensure investigations, stipulations, letters of admonition or concern, voluntary or involuntary suspensions, relinquishments, terminations and denials, in whole or in part, of any license to practice medicine or dentistry in any state, DEA restrictions, stipulations, suspensions, relinquishments, terminations, any reports made concerning the applicant to the National Practitioner Data Bank, licensing entities and other state or federal agencies, any charges and convictions of a felony, and any actual or proposed exclusion from participation in any government sponsored health care program. Failure to provide and update information as required in this Section 3.2-8 or in other Sections of this Credentials Manual may be grounds for automatic administrative termination of Staff appointment and Clinical Privileges, without

rights of hearing and appellate review, and/or such other action as the Hospital or its Medical Staff deem appropriate.

3.2-9 Agrees that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall constitute an automatic withdrawal of the application for appointment, reappointment or reinstatement. Medical Staff appointment and Clinical Privileges of those applying for reappointment shall expire on the date such current appointment is due to expire, or if such appointment has already expired, the current appointment and Clinical Privileges shall expire upon notice of the automatic withdrawal of the application for reappointment. An automatic withdrawal of the application for appointment or reappointment, as applicable, does not entitle the affected applicant or Staff Appointee, whichever is applicable, to any of the procedural rights or processes outlined in this Credentials Manual or other bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff. In the event that an appointment has been granted prior to discovery of such misrepresentation, misstatement or omission, the discovery of such misrepresentation or misstatement may result in automatic revocation of Medical Staff appointment and Clinical Privileges. A reapplication for membership on the Medical Staff may be submitted at a future date, the acceptance of which will be at the sole discretion of the MEC. No right of hearing or appeal shall be available in such cases.

3.2-10 If an application is received from an applicant who has been previously denied membership on the Medical Staff, or whose application was incomplete and/or withdrawn, or who previously was a member of the Staff but whose membership and/or Clinical Privileges were terminated due to lack of sufficient qualifications required to maintain his/her membership, and it appears that the application is based on substantially the same information as when previously denied, withdrawn or terminated, the application may be deemed insufficient by the MEC and will not be processed and the applicant will be so notified. No right of hearing or appeal shall be available in such cases. An application for membership on the Medical Staff may be received or rejected at a future date at the sole discretion of the MEC.

3.3 PROCEDURE FOR PROCESSING APPLICATIONS FOR STAFF APPOINTMENT

3.3-1 An application must be returned to the Medical Staff office. The applicant shall have the sole burden of producing requested information for an evaluation of his/her eligibility, competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. The following documentation and information is required.

A. A typed or legibly written, completed and signed application form and request for Clinical Privileges;

B. A copy of current Colorado license or proof of exemption and a copy of other state licensure and, where applicable, DEA certificate;

C. A copy of current professional liability insurance policy or other proof of compliance with the requirements of Section 2.2-2;

D. Copies of diplomas demonstrating completion of a accredited educational institute and copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum;

E. Verification (copy of certificates or copy of letter from appropriate specialty board) of specialty board status, i.e., board eligibility or board certification;

F. Three (3) letters of recommendation must be sent directly to the CEO from persons who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who can and will provide reliable information regarding current clinical ability, ethical character and ability to work with others;

G. Payment of the application fee; and

H. The Hospital or its Medical Staff or any Committee may request such other information at any time during the application process. Once additional information is requested, the application shall be deemed incomplete and further processing will be stayed pending receipt of the requested information.

3.3-2 Once an application has been received in the Medical Staff office, all additional information requested must be submitted within 15 days of the request. If the applicant fails to completely respond to or comply with any request for additional information, assistance or an interview, within thirty (30) days of such a request, the entire application or the request for Clinical Privileges, which are the subject of the request for additional information, assistance or interview, depending upon the nature and extent of the additional information, assistance or interview requested, may be deemed withdrawn and no further processing will take place. The MEC shall determine whether an application or request for Clinical Privileges will be deemed withdrawn in whole or in part. An applicant whose application is deemed withdrawn is not entitled to any of the procedural rights or processes outlined in this Credentials Manual. Notice of the withdrawal shall be provided to the applicant.

3.3-3 Upon receipt of an application and all supporting documents and information, the CEO will verify its contents and may collect additional information as follows:

A. Information from all prior and current insurance carriers concerning claims, suits and settlements (if any) during the past five (5) years;

B. Secure clinical reference questionnaires and administrative references from all past practice settings for the previous five (5) years;

C. A verified report documenting the applicant's clinical work during the past twelve (12) months;

D. Verification of licensure status in all current or past states of licensure;

E. Information from the Federation of State Medical Boards or other applicable association or board;

F. The AMA Physician Masterfile Profile (or its equivalent);

G. Information from the National Practitioners' Data Bank established pursuant to the Healthcare Quality Improvement Act of 1986;

H. Information relating to the applicant's conduct as described in the Physician/Allied Health Staff Policy Regarding Disruptive Conduct; and,

I. Such additional information as the Hospital or its Medical Staff may request.

3.3-4 The MEC shall review the application and all supporting and additional information. The MEC may, in its sole discretion, request additional information, and/or additional assistance from and/or an interview with the applicant. The interview, if requested, at the sole discretion of the MEC, shall be informal and none of the rights or processes outlined in the Credentials Manual shall apply thereto. The processing of the application shall be stayed during the pendency of the request for additional information, assistance and/or an interview which shall be provided/completed by the applicant within thirty (30) days of the date of the request or the application may be deemed withdrawn, in whole or in part, as provided in Section 3.3-2. Once the MEC's review of the application and supporting information is complete, the MEC shall forward to the CEO for transmittal to the Board, a written report and recommendation as to the granting of Staff appointment, Staff category, Committee affiliation and Clinical Privileges and any special conditions to be attached or considered in the final decision regarding appointment. The MEC may also defer action on the application pursuant to Section 3.4.

The basis for the MEC recommendation should be stated and may be supported by references to the completed application, reports and/or all other information and documentation considered by the MEC, all of which shall be transmitted with the MEC report and recommendation.

3.4 EFFECT OF MEC ACTION

3.4-1 **DEFERRAL:** Action by the MEC to defer the application for further consideration should state the reasons for such deferral, provide direction for

further investigation and state time periods for such further investigation and report back to the MEC. The MEC may defer the application for further consideration to an ad hoc Committee, as it deems appropriate. After receipt of the report following deferral, the MEC shall review the matter and either defer the application for further consideration or make its report its report and recommendation in the matter.

3.4-2 **FAVORABLE RECOMMENDATION:** When the recommendation of the MEC is favorable to the applicant, the CEO shall promptly forward it, together with all supporting documentation, to the Board. For the purposes of this Section 3.4-2 "all supporting documentation" includes the application form and its accompanying information.

3.4-3 **ADVERSE RECOMMENDATION:** When the recommendation of the MEC is adverse to the applicant, as outlined in this Credentials Manual, the CEO shall so inform the applicant of his/her procedural rights as provided in this Credentials Manual. The MEC's adverse recommendation shall not be forwarded to the Board until the applicant has either exhausted the procedural rights outlined in this Credentials Manual or is deemed to have waived those rights.

3.5 BOARD ACTION

3.5-1 **ON A FAVORABLE 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 and setting a time limit within which a subsequent recommendation should be made. Favorable action by the Board is effective as its final action. If, after complying with the requirements, the Board's action is adverse to the applicant, notice will be sent to him/her and he/she shall then be entitled to exercise or waive the procedural rights outlined in this Credentials Manual.

3.5-2 **AFTER PROCEDURAL RIGHTS:** In the case of an adverse MEC recommendation, the Board shall take final action only after the applicant has exhausted or waived the hearing and appellate review processes outlined in this Credentials Manual.

3.5-3 **ADVERSE BOARD ACTION DEFINED:** "Adverse action" by the Board is outlined in this Credentials Manual.

3.6 NOTICE OF FINAL DECISION

3.6-1 Notice of the final decision by the Board shall be given through the CEO to the MEC and to the Chairperson of each applicable Committee. The applicant shall receive written notice of appointment and notice of any adverse final decision, as applicable.

3.6-2 A decision and notice of appointment includes:

A. The Staff category to which the applicant is appointed;

B. The Committee to which he/she is assigned;

C. The Clinical Privileges he/she may exercise; and

D. Any special conditions attached to the appointment.

3.6-3 The new appointee will be notified in writing by the CEO of the action of the Board. The signature of the CEO will indicate approval by the Board provisionally appointing the applicant with specified Clinical Privileges to the indicated category of the Medical Staff.

3.7 REAPPLICATION AFTER ADVERSE APPOINTMENT ACTION OR CORRECTIVE ACTION

An applicant who has received a final adverse decision regarding his/her application for appointment or reappointment and a Practitioner whose Staff appointment and/or Clinical Privileges are suspended, limited, revoked or terminated shall not be eligible to reapply for Staff appointment and/or Clinical Privileges for a period of one (1) year following a final adverse appointment or corrective action decision. If, after receiving the completed application of an applicant who had a previous application for appointment or reappointment denied, or an applicant whose Medical Staff appointment and/or Clinical Privileges at the Hospital were suspended, limited, revoked or terminated, in whole or in part, the MEC President, the MEC, and/or any Committee, in consultation with the CEO or the Board, determines that the applicant has not provided sufficient information that was either not available or not presented at the time he/she previously applied for Staff appointment or reappointment, as applicable, and/or Clinical Privileges or was subject to corrective action, as applicable, that addresses the reasons Staff appointment and/or Clinical Privileges were previously denied, suspended, limited, revoked or terminated, in whole or in part, as applicable, his/her application can be summarily denied and the applicant is not entitled to the procedural rights and processes outlined in this Credentials Manual. Board action is not required for a summary denial of an application as provided in this Section. Any such reapplication that is not summarily denied shall be processed as an initial application, and the applicant shall provide additional information, assistance and/or an interview as the Hospital or its Medical Staff may request. However, it is the applicant's burden to demonstrate that the basis of the earlier adverse action no longer exists.

ARTICLE IV: REAPPOINTMENT

ALL REAPPOINTMENTS ARE FOR A PERIOD NOT TO EXCEED TWO (2) YEARS.

4.1 INFORMATION COLLECTION AND VERIFICATION

4.1-1 **FROM MEDICAL STAFF APPOINTEES:** At least 180 days prior to the date of expiration of a Medical Staff appointment, the CEO notifies the appointee of the date of expiration of Staff appointment. At least one hundred and fifty (150) days prior to expiration of Staff appointment, the appointee, furnishes in writing:

A. Complete information to update his/her file on items listed in his/her original application (See Sections 3.2-8 and 3.3-1) and information provided to support his/her previous application;

B. Continuing training and education external to the Hospital received during the period of current appointment;

C. Specific request for the Clinical Privileges sought on reappointment and documentation to support a request for review of new or additional Clinical Privileges;

D. Requests for changes in Medical Staff category or Committee assignments;

E. Two (2) peer references (physicians requesting Consulting staff category must provide peer references which attest to his/her competency);

F. Such additional information as the Hospital or its Medical Staff may request.

Failure, without good cause, to provide this information at least one hundred and fifty (150) days prior to the expiration of Staff appointment may result in the application for reappointment being deemed withdrawn and automatically results in expiration of appointment upon the date current appointment is due to expire. Failure to completely respond and comply within thirty (30) days with a request, for additional information, assistance or an interview is deemed a voluntary withdrawal of the application and may automatically result in expiration of appointment upon the date current appointment is due to expire. The MEC shall determine whether an application is deemed withdrawn, in whole or in part. The CEO shall verify the information submitted, and shall notify the Staff appointee of the need for additional information, assistance, an interview and/or verification problems. The Staff appointee then has the burden of producing the required and requested information and resolving any doubts about the data. The Practitioner's obligations hereunder are not affected by the Hospital's failure to provide timely notice of the date of expiration of Staff appointment. A Practitioner whose application is deemed withdrawn is not entitled to any of the procedural rights or

processes outlined in this Credentials Manual. Notice of the withdrawal shall be provided to the Staff appointee.

4.1-2 **FROM INTERNAL AND/OR EXTERNAL SOURCES:** Based upon the information provided by the Staff appointee, the CEO verifies and gathers information regarding the Practitioner's professional and collegial activities, performance and conduct in the Hospital and/or other health care facilities. Such information includes, without limitation: patterns of care as demonstrated in findings of quality improvement activities; medical records/Hospital reports; continuing education activities; attendance at required Medical Staff and Committee meetings; service on Medical Staff, Committee, and Hospital Committees; timely and accurate completion of medical records; compliance with all applicable bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff. By accepting appointment, all appointees authorize and consent to the Hospital's exchange of information as outlined in the bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff.

4.1-3 All documents shall be reviewed and verified as described in the Article III.

4.1-4 The CEO will compile a summary of clinical activity for each appointee requesting reappointment.

4.2 PROCEDURE FOR PROCESSING APPLICATIONS FOR STAFF REAPPOINTMENT

4.2-1 **MEC ACTION:** The MEC shall review each application for reappointment, all supporting documentation and all other information requested by the Hospital, its Medical Staff or any Committee and shall act on the application in the manner described in Section 3.4-1 through 3.4-3.

4.2-2 **PROCESSING AND BOARD ACTION**

A. The procedure for Board action outlined in Section 3.5 shall apply.

B. If the processing of the application for reappointment of the Staff appointee has not been completed by the expiration date of the appointment, the processes outlined in Section 4.1-1 shall apply. Any extension of Staff appointment and/or Clinical Privileges shall not be deemed to create a right that the application for reappointment of the Staff appointee is automatically granted for the coming term.

C. It is intended that Sections 3.2, 3.3-2, and 3.7 apply to applicants for reappointment and such Sections are incorporated herein by reference.

4.2-3 **REQUEST FOR MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES:** A Staff appointee, either in connection with reappointment or at any other time, may request modification of his/her Staff category, Committee

assignment, or Clinical Privileges by submitting a written application to the MEC. An application for modification is processed in the same manner as an application for reappointment. All requests for increased privileges must be accompanied by information demonstrating eligibility, education, training, qualifications, experience and current clinical competence in the specific privilege requested and may be granted on a provisional basis.

ARTICLE V: CLINICAL PRIVILEGES

5.1 **EXERCISE OF PRIVILEGES:** A Practitioner providing clinical services at the Hospital may exercise only those privileges granted to him/her by the Board or emergency privileges as described herein.

5.2 **PRIVILEGES IN GENERAL**

5.2-1 **REQUESTS:** Each application for appointment or reappointment to the Medical Staff must contain a request for specific Clinical Privileges desired by the applicant. Specific requests must also be submitted for temporary privileges and for modification of privileges in the interim between reappointment evaluations.

5.2-2 **BASIS FOR PRIVILEGES DETERMINATION:** Requests for Clinical Privileges will be considered only when accompanied by evidence of education, training, experience and demonstrated competence as specified by the Hospital. In the event a request is submitted for which no criteria have been created or for a privilege that is not currently available the request may be tabled for a reasonable period of time during which the Board shall, after consultation with the MEC, formulate the necessary criteria and/or make a decision whether the privilege is available at the Hospital. Once objective criteria have been established the original request shall be processed as described herein.

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. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed or known (if observation is waived) clinical performance and documented results of the Staff's quality improvement program activities. Privileges determinations shall also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises Clinical Privileges. The information shall be added to and maintained in the Medical Staff file established regarding the Staff appointee.

5.3 **SPECIAL CONDITIONS FOR DENTAL PRIVILEGES:** Requests for Clinical Privileges for dentists are processed in the manner outlined herein. Surgical procedures performed by dentists will be under the overall supervision of the Committee Chairperson of the Surgery Committee. All dental patients shall receive a basic medical appraisal by an Active physician appointee to the Medical Staff, except that oral surgeons with

appropriate training, qualifications and privileges may perform the medical appraisal. A physician appointee to the Medical Staff shall also be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalizations. The responsible physician shall have the responsibility for the overall medical care of the patient and any surgical procedure performed must be with his/her knowledge and concurrence and he/she must hold Clinical Privileges for any procedure provided with his/her knowledge and concurrence.

5.4 **SPECIAL CONDITIONS FOR ALLIED HEALTH PRACTITIONERS:** Requests to perform specified patient care services from AHPs are processed in the manner outlined in Article IV, Section 4.6 of the Bylaws. An AHP may, subject to any licensure requirements or other limitations, participate directly in the medical management of patients only under the supervision of a Practitioner who has been accorded privileges to provide such care.

5.5 **TEMPORARY PRIVILEGES**

5.5-1 Temporary Clinical Privileges can be issued for important patient care needs for a limited time, as defined in this Credentials Manual. Temporary Privileges can also be issued for new applicants.

5.5-2 Temporary Privileges may be granted for a period of time not to exceed 120 days on a case-by-case basis when an important patient care need mandates an immediate authorization to practice while the full credentials information is verified and approved. Examples include a situation in which a physician becomes ill or takes a leave of absence and another physician would need to cover his/her practice until he/she returns, or a specific physician has the necessary skills to provide care to a patient that no physician currently privileged possesses. In these circumstances, the CEO, upon the recommendation of either the applicable Committee Chairperson or the MEC President, may grant Temporary Privileges, if current licensure and competence are verified and the conditions set forth in Section 5.5-5 are met.

5.5-3 Temporary Privileges may be granted for a period of up to 120 days when a new applicant for Medical Staff membership or privileges is waiting for a review and recommendation by the MEC and approval by the governing Board. The CEO may grant Temporary Privileges upon recommendation of either the applicable Committee Chairperson or the MEC President, if:

A. there is verification (which may be accomplished through a telephone call) of:

1. current licensure,

2. relevant training or experience,

3. current competence,

4. liability insurance requirements of the Hospital or state or federal law, whichever is highest, unless exempt under the provisions of Section 2.2-2,

5. ability to perform the Privileges requested, and

6. other criteria required by the Bylaws of the Medical Staff or this Credentials Manual; and

B. the results of the National Practitioner Data Bank query have been obtained and evaluated; and

C. the applicant has:

1. a complete application,

2. no current or previously successful challenge to licensure or registration,

3. not been subject to involuntary termination of medical staff membership at another organization, and

4. not been subject to involuntary limitation, reduction, denial, or loss of Clinical Privileges.

5.5-4 The Committee Chairperson responsible for supervision may impose special requirements of consultation and reporting. Except in unusual circumstances, Temporary Privileges will not be granted unless the individual has agreed in writing to abide by the bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff in all matters relating to his/her Temporary Privileges. Whether or not such written agreement is obtained, Medical Staff Documents control all matters relating to the exercise of Clinical Privileges.

5.5-5 **CIRCUMSTANCES:** Upon concurrence of the Committee Chairperson over the Committee where the Privileges will be exercised, or the MEC President, the CEO may grant Temporary Privileges in the following circumstances:

A. **Care of Specific Patients:** Upon receipt of a request, either written or via telephone, for specific Temporary Privileges for the care of one or more specific patients, and receipt of the required information from a individual who is not an applicant for Staff appointment, such Privileges shall be granted no more than three (3) times in any twelve (12) month period; or

B. **Locum Tenens:** Upon receipt of a written request for specific Temporary Privileges, an appropriately licensed individual of documented competence who is serving as a locum tenens for an appointee to the

Medical Staff may, without applying for appointment on the Staff, be granted Temporary Privileges; or

C. **Medical Residents:** Temporary Privileges may be granted in approved training programs acting under the supervision of an appointee to the Medical Staff who meet qualifications as required by the MEC or Hospital; or

D. **Organ Recovery:** Temporary Privileges may be granted upon receipt of a request for organ recovery surgery on a brain-dead patient, and receipt of information documenting licensure, required malpractice insurance or other coverage as specified in Section 2.2-2, and verification from the surgeon that he/she has privileges to perform organ recovery at another institution.

5.5-6 **TERMINATION OF TEMPORARY PRIVILEGES:** The MEC President or the CEO, after consultation with the appropriate Committee Chairperson, on the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the Temporary Privileges granted, may at any other time terminate any or all of a Practitioner's Temporary Privileges, provided that where the life or well being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspension as outlined in this Credentials Manual. In the event of any such termination, the Committee Chairperson responsible for supervision shall assign the Practitioner's patients then in the Hospital to another Practitioner. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

5.5-7 **RIGHTS OF THE PRACTITIONER WITH TEMPORARY PRIVILEGES:** A Practitioner is not entitled to the procedural rights outlined in this Credentials Manual because his/her request for Temporary Privileges is refused or because all or any part of his/her Temporary Privileges are terminated, limited or suspended unless the suspension, limitation or termination of Temporary Privileges adversely impacts the Temporary Privileges granted and will have such an adverse impact for a period longer than thirty (30) days.

5.6 **DISASTER/EMERGENCY PRIVILEGES:** During disaster(s) in which an emergency management plan has been activated, the CEO and Medical Staff President or their designee(s) have the option to grant Disaster/Emergency Privileges upon the presentation of any of the following:

- A current picture hospital ID card
- A current license to practice and a valid picture ID issued by any state, federal, or regulatory agency

- Identification indicating that the individual is a member of a disaster medical assistance team (DMAT).

- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)

- Presentation by the current Hospital or Medical Staff member(s) with personal knowledge regarding practitioner's identity.

They are not required to grant Privileges to any individual and are expected to make such decisions on a case-by-case basis at their discretion.

Individuals who receive Disaster/Emergency Privileges are to take direction from Officers of the Medical Staff when available, and, when not, from members of the Medical Staff with Active status. Individuals who are granted Disaster/Emergency Privileges shall be identified by a name badge which contains the notation: "Emergency Privileges."

The individual who grants Disaster/Emergency Privileges begins the verification process of the credentials and Privileges of individuals who receive such Privileges as soon as the immediate situation is under control.

This verification process becomes a high priority and is identical to the process established herein for granting Temporary Privileges to meet an important patient care need.

In case of a disaster or emergency, any Medical Staff appointee with Clinical Privileges is "Temporarily Privileged" and is authorized to do everything possible to save the patient's life or to save the patient from serious harm, regardless of Committee affiliation, Staff category, or level of Privileges, so long as the care provided is within the scope of the Practitioner's license. A Practitioner exercising Emergency Privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up. In the event that residents involved in an approved graduate medical education program are assigned to service in the Hospital, properly supervised residents may provide such emergency care.

ARTICLE VI: INVESTIGATION AND CORRECTIVE ACTION POLICY

6.1 SCOPE OF POLICY

6.1-1 This policy shall not apply to issues that are addressed in the Physician/Allied Health Staff Policy Regarding Disruptive Conduct and/or Practitioner Health Plan of SLV Regional Medical Center, unless the MEC determines that the issue relate directly to patient care and require peer review involving medical judgment.

6.2 BEHAVIOR LEADING TO INITIATION OF INVESTIGATION

6.2-1 **ROUTINE INVESTIGATION:** Routine investigation may be initiated whenever a Practitioner with Staff appointment and/or Clinical Privileges engages in, makes or exhibits an act, statement, demeanor or professional conduct either within or outside the Hospital, and the same is, or is reasonably likely to be detrimental to the quality of patient care or safety, disruptive to the Hospital's operations, or an impairment to the community's confidence in the Hospital.

6.2-2 **AUTOMATIC SUSPENSION:** Automatic suspension shall be initiated, as deemed appropriate, whenever there is revocation, suspension, restriction or probation of or stipulation regarding the Practitioner's state license or DEA number; whenever there is failure to satisfy a special appearance requirement; whenever the Practitioner fails to maintain malpractice insurance in such form or amounts required by the Hospital or state or federal law, whichever is highest, unless exempt under the provisions of Section 2.2-2 above; whenever a Practitioner's medical records are not completed in a timely manner and whenever circumstances exist that shall result in an automatic suspension as outlined in this Credentials Manual or the Medical Staff Documents.

6.2-3 **INVESTIGATORY SUSPENSION:** An investigatory suspension may be imposed for a period of no more than fourteen days to allow for investigation and consideration of whether there is a need for potential professional review corrective action. Imposition of an investigatory suspension shall not entitle the Practitioner to any procedural hearing or appellate review rights. An investigatory suspension must either be terminated by the end of the fourteenth day or be converted, if warranted, to a summary suspension.

6.2-4 **SUMMARY SUSPENSION:** Summary suspension shall be initiated whenever a Practitioner's conduct requires that immediate action be taken to prevent immediate danger to life, or substantial likelihood of injury to patients, employees or other persons present in the Hospital.

6.3 **INTERVIEWS PRIOR TO INVESTIGATION AND CORRECTIVE ACTION:** When considering initiating investigation or corrective action, the MEC or the Committee or individual appointed to investigate the matter may, at their discretion, arrange for an interview with the affected Practitioner. At the interview, circumstances prompting the consideration of investigation or corrective action may be discussed and the Practitioner may be asked to present relevant information on his/her own behalf. A written record should be maintained reflecting the substance of the interview, which shall be treated and maintained as professional review information. If the Practitioner fails or declines to participate in the interview, the appropriate investigation or corrective action is initiated. This interview is not a procedural right of the Practitioner and need not be conducted according to the procedural rights or processes outlined in this Credentials Manual.

6.4 **INVESTIGATION AND ROUTINE REVIEW:** Nothing in this Article VI is intended to place requirements upon or affect routine reviews regarding quality of care, utilization reviews and professional conduct.

6.4-1 **REQUESTS AND NOTICES:** All requests for investigation for potential corrective action must be in writing, submitted to or created by the MEC and supported by reference to specific activities or conduct that constitute grounds for the request. Any Medical Staff appointee, AHP, CEO or member of the Board may make a request for investigation for potential corrective action. The MEC President shall promptly notify the CEO of all requests for investigation for potential corrective action.

6.4-2 **INVESTIGATION:** After deliberation, the MEC may either act on the request, or direct that an investigation be undertaken. The MEC may conduct such investigation itself or may assign this task to a Medical Staff officer, Committee, or ad hoc Committee or other organizational component. External third parties may be utilized in the investigation process to be part of or conduct the investigation, as determined by the MEC. The investigative process is not a "hearing" as that term is used in this Credentials Manual. It may involve a consultation with the Practitioner 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 conducted 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 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 investigation process and proceed with action as provided below. The CEO shall notify the affected Practitioner of the initiation of an investigation by the MEC.

Processes employed during routine professional review which will not be considered an investigation, include but are not limited to:

A. Requests for and/or review of information not always requested and/or reviewed.

B. The imposition of intensified review, including concurrent and/or retrospective review, observation requirements, education requirements that do not limit or restrict current Medical Staff appointment and/or Clinical Privileges as determined by the MEC.

C. The assignment of quality appraisal levels.

D. Action taken by a clinical Committee or other professional review Committee other than the MEC, as a result thereof, unless an investigation is expressly initiated by the MEC as outlined in this Article, professional/peer review processes, are considered routine

professional/peer review and such processes do not constitute an investigation.

An Investigation may only be initiated by the MEC as outlined above.

6.4-3 **MEC ACTION:** As soon as practicable after conclusion of the investigation, but in any event at its next regularly scheduled meeting after conclusion of the investigation and provision of the report of the investigation, the MEC should act upon the report of such investigation. Its action may include, without limitation, recommending:

A. Rejection of the request for investigation;

B. A warning or a formal letter of admonition or reprimand;

C. A probationary period with retrospective review of cases but without special requirements for concurrent consultation or direct supervision;

D. Suspension of appointment prerogatives that do not affect Clinical Privileges;

E. Individual requirements for consultation or supervision;

F. Reduction, suspension, limitation or revocation of Clinical Privileges;

G. Reduction of Staff category or suspension or limitation of prerogatives directly related to the Practitioner's provision of patient care;

H. Suspension or revocation of Staff appointment; and

I. Such other action the MEC deems appropriate.

6.4-4 **DEFERRAL:** If additional time is needed to complete its deliberations or additional information is needed, the MEC may defer action on the request. The deferral should establish a time period for completion of the additional investigation or deliberations, and a recommendation for any one or more of the actions provided above should be made at least at the next regularly scheduled meeting of the MEC after receiving the report after deferral.

6.4-5 **PROCEDURAL RIGHTS:** Only an adverse recommendation, as outlined in Section 8.2-2 of this Credentials Manual entitles the Practitioner to the procedural rights and processes outlined herein.

6.5 AUTOMATIC SUSPENSION

6.5-1 **STATE LICENSE:** By accepting Staff appointment, each appointee agrees to notify the Hospital, through its Medical Staff office, within twenty-four (24) hours of the effective date of any suspension, termination, limitation or stipulation

or other action taken by the Colorado Board of Medical Examiners or other applicable licensing entity with regard to his/her license to practice medicine in Colorado which adversely impacts or limits his/her ability to practice his/her profession in Colorado. Each appointee also agrees to notify within seven (7) days of the effective date of the action, as outlined in Section 3.2-8, of any investigation, stipulation, letter of warning or admonition or other action taken by the Colorado State Board of Medical Examiners or other appropriate licensing entity.

A. **Revocation:** Whenever a Practitioner's license to practice in this state is revoked, there is immediate and automatic revocation of Staff appointment and all Clinical Privileges.

B. **Restriction or Stipulation:** Whenever a Practitioner's license is partially limited, restricted or under stipulation in any way, those Clinical Privileges which he/she has been granted that are within the scope of the limitation or restriction are similarly limited, restricted or under stipulation automatically.

C. **Suspension:** If a license is suspended, the Practitioner's Staff appointment and Clinical Privileges are automatically suspended effective upon and for at least the term of the suspension and until such appointment and privileges are reinstated by the Hospital.

D. **Probation:** If a Practitioner is placed on probation by his/her licensing authority, his/her voting and office holding prerogatives are automatically suspended effective upon and for at least the term of the probation and until such voting and office holding prerogatives are reinstated by the Hospital.

6.5-2 **DRUG ENFORCEMENT (DEA):** If a Practitioner's right to prescribe controlled substances is revoked, restricted, suspended, put under a stipulation or placed on probation by a proper licensing or regulating authority, his/her privileges to prescribe such substances in the Hospital will also be revoked, restricted, suspended, or placed on stipulation or probation automatically and to the same degree. This will be effective upon and for at least the term of the imposed restriction. Every Practitioner, by accepting Staff appointment, agrees to notify the Hospital, through its Medical Staff office, within twenty-four (24) hours of any action taken by a proper licensing or regulating authority with regard to the Practitioner's right to prescribe medication, in addition to the obligations outlined in Section 3.2-8.

6.5-3 **MEDICAL RECORDS PREPARATION AND COMPLETION:** The rules for medical records preparation and completion are outlined in the Medical Staff Documents. Failure to complete the medical record within thirty (30) days after the patient's discharge or completion of outpatient or emergency services shall result in notification to the Practitioner of such delinquency by the CEO.

Justifiable reasons for delay in completing records must be documented and submitted to the appropriate individuals/Committees and include, without limitation:

A. The Practitioner is ill or otherwise unavailable, for a period of time due to circumstances beyond his/her control. The MEC President will consider other extenuating circumstances.

B. The Practitioner is waiting for results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis; and

C. The Practitioner has dictated reports and is waiting for Hospital personnel to transcribe them.

Timely Completion: The repeated failure to prepare and/or to complete medical records in a timely fashion may result in corrective action regarding a Practitioner's Staff appointment and some or all Clinical Privileges.

A Practitioner whose admitting prerogatives are suspended due to the first violation of Section 6.5-3 will be automatically reinstated upon demonstration to Medical Records staff of satisfactory completion of delinquent records.

Voluntary Resignation: Three (3) suspensions of admitting privileges within any twelve (12) month period for failure to timely complete or prepare records will be deemed a voluntary resignation of Staff appointment and Clinical Privileges. Practitioners who are deemed to have voluntarily resigned Staff appointment and Clinical Privileges are not entitled to the procedural rights and processes outlined in of this Credentials Manual. Practitioners who so resign may immediately submit an application for appointment. Any such application shall be treated and processed as an application for initial appointment. All information relating to the Practitioner's actions and conduct during his/her previous appointments to the Medical Staff may be considered.

6.5-4 **PROFESSIONAL LIABILITY INSURANCE:** Unless exempt under the provisions of Section 2.2-2 above, a Practitioner's Medical Staff appointment and Clinical Privileges are automatically suspended for failure to maintain professional liability insurance or provide evidence of participation in a Federal Tort Reform Program in such amounts as required by the Hospital or state or federal law, whichever is highest, but in no event in an amount less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate. Practitioners must notify the Medical Staff Office within twenty-four (24) hours of any termination, cancellation, reduction or limitation in professional liability insurance coverage or any change in

circumstances under which the Practitioner has been exempt from the requirement for such coverage under Section 2.2-2.

6.5-5 **EMERGENCY BACK-UP CALL SCHEDULE:** Refusal or failure to sign up for and/or accept assignment to Emergency Back-Up call schedule as required by a Medical Staff Committee policy may result in automatic suspension of Staff appointment and/or Clinical Privileges and/or other corrective action as the Hospital or its Medical Staff deems appropriate.

A. **Emergency Back-Up Call Sign-Up or Acceptance of Assignment and Response:** A Practitioner who fails to sign up and/or accept assignment for ER Back-Up Call in their specialty, shall, upon the first occurrence receive a written warning from the applicable Committee Chairperson of the Hospital. A Practitioner who refuses or fails to respond in a timely manner, as determined by the Hospital and/or its Medical Staff, to emergency room call upon the first occurrence receive a written warning from the applicable Committee Chairperson of the Hospital.

B. **Responding to Emergency Call:** The first time in a twenty-four (24) month period a Medical Staff appointee refuses or fails to respond in a timely manner, as determined by the Hospital and/or its Medical Staff, to emergency call, the Medical Staff appointee must, within seven (7) days after receiving notice of such failure or refusal, submit a satisfactory explanation, as determined by the Practitioner's Committee Chairperson. If the Committee Chairperson determines that the explanation is unsatisfactory, he/she may refer the matter for investigation for possible corrective action. The second failure or refusal to sign up for and/or accept call or to respond in a timely manner, as determined by the Hospital and/or its Medical Staff, to ER call within a twenty-four (24) month period shall result in automatic suspension.

6.5-6 **PROVISION OF ALTERNATE COVERAGE:** The first time in a twenty-four (24) month period a Medical Staff appointee fails to provide coverage as required, the Medical Staff appointee must, within seven (7) days after receiving notice of such failure, submit a satisfactory explanation as determined by the Practitioner's Committee Chairperson. If the Committee Chairperson determines the explanation is unsatisfactory, he/she may refer the matter for investigation for possible corrective action. The second failure to provide coverage as required within a twenty-four (24) month period shall result in automatic suspension.

6.5-7 **COMPLIANCE WITH MEDICAL STAFF/HOSPITAL DOCUMENTS AND REQUIREMENTS:** A Practitioner's failure to comply, in whole or in part, with restrictions, limitations and/or requirements placed on the Practitioner's Medical Staff appointment and/or Clinical Privileges shall result in automatic suspension of all or part of the Practitioner's Medical Staff appointment and/or Clinical Privileges, as determined by the MEC President, CEO or the Board.

6.5-8 **PROCEDURAL RIGHTS:** A Practitioner whose Medical Staff appointment and/or Clinical Privileges are automatically diminished, restricted, suspended, revoked or limited pursuant to this Section 6.5 shall not be entitled to the procedural rights and processes outlined in this Credentials Manual.

A Practitioner whose Medical Staff appointment and/or Clinical Privileges or admitting prerogatives are automatically suspended must submit a written request for reinstatement during regular business hours to the Medical Staff office with documented proof that the deficiencies leading to the suspension have been corrected. The Practitioner may be reinstated if the MEC President, in consultation with the CEO, determines the deficiencies or occurrences that resulted in the automatic suspension have been corrected. If the request for reinstatement is denied, the Practitioner is entitled to the procedural rights and processes outlined in this Credentials Manual and, not later than the end of the fifth working day after the date reinstatement was denied, the CEO shall give the affected Practitioner notice of the denial of his/her request for reinstatement. Failure to request reinstatement within ninety (90) days of the automatic suspension or action shall be deemed a voluntary resignation from the Medical Staff and the affected Practitioner is not entitled to exercise the procedural rights and processes outlined in this Credentials Manual.

6.5-9 **NOTICE:** A Practitioner who is automatically suspended by operation of this Section 6.5 shall be given notice of such automatic suspension or action by the CEO, by first class or certified mail, postage prepaid or by hand delivery, after imposition of such automatic suspension or action. Such notice shall state the reasons for such automatic suspension or action and refer the Practitioner to the process to be followed to release the automatic suspension or action.

6.6 **SUMMARY SUSPENSION:** Summary suspension may be initiated by any Medical Staff Officer, Committee Chairperson, the MEC or the CEO. They have the authority to summarily suspend the Medical Staff appointment and/or all or any portion of the Clinical Privileges of such Practitioner. A summary suspension is effective immediately and the CEO is to give prompt notice of the suspension to the Practitioner. A summary suspension lasts until it is terminated by official action.

6.6-1 **MEC ACTION:** As soon as convenient and generally within five (5) working days after the summary suspension has been imposed, the MEC shall convene to review and consider the summary suspension taken. The MEC may recommend modification, continuation, or termination of the terms of the suspension. If the MEC initiated the summary suspension, no additional review is required.

6.6-2 **PROCEDURAL RIGHTS:** Unless the MEC recommends immediate termination of or modification of the summary suspension to one of the lesser sanctions as outlined herein, or if the summary suspension is initiated by the MEC, the Practitioner should be notified and is entitled to the procedural rights and processes outlined in this Credentials Manual. However, if the MEC continues a suspension as an investigatory suspension, the procedural rights and

processes outlined herein shall not be triggered until after the MEC has concluded its investigation, and then only if the MEC's action and recommendation is adverse as outlined in this Credentials Manual.

6.6-3 **OTHER ACTION:** A MEC recommendation to terminate or modify the suspension to a lesser sanction that is not adverse, as outlined in Section 8.2-2, is transmitted immediately, together with all supporting documentation, to the Board. In the instance of a favorable MEC recommendation, the MEC's recommendation will have the effect of revoking the summary suspension completely or reinstating the Practitioner with whatever corrective action was assessed by the MEC preceding the final decision of the Board.

6.7 A suspended Practitioner's patients then in the Hospital must be assigned to another Practitioner by the appropriate Committee Chairperson or his/her designee. This assignment should consider the wishes of the patient in choosing a substitute Practitioner when feasible.

ARTICLE VII: LEAVE OF ABSENCE

7.1 **LEAVE STATUS:** A Staff appointee may obtain a voluntary leave of absence by giving written notice to the MEC President for transmittal to the appropriate Committee Chairperson and the CEO. 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 time of the leave the Staff appointee's Clinical Privileges, prerogatives and responsibilities may not be exercised.

7.2 **TERMINATION OF LEAVE:** The Staff appointee must, at least thirty (30) days prior to the termination of the leave, or may at any earlier time, request reinstatement by sending a written notice to the MEC, except that if Staff appointment expires during the leave, the Staff appointee must submit a completed application for reappointment on a timely basis. Failure to submit an application for reappointment on a timely basis may result in expiration of Staff appointment and Clinical Privileges or voluntary resignation thereof. If Staff appointment and Clinical Privileges expire or are resigned, the Practitioner will be required to submit a new application that will be processed as an application for initial appointment. The Staff appointee requesting reinstatement, reappointment or appointment must submit a written summary of relevant activities during the leave if the MEC or Board so requests and such other information requested by the Hospital or its Medical Staff. The MEC shall make a recommendation to the Board concerning reinstatement, if the Practitioner's Medical Staff appointment and Clinical Privileges have not expired by the time reinstatement is requested, otherwise the applicable processes for further processing the application are outlined in this Manual.

ARTICLE VIII: HEARING AND APPELLATE REVIEW

8.1 **INITIATION OF HEARING:** An applicant, or a Practitioner holding Medical Staff appointment, shall be entitled to a hearing whenever an adverse recommendation affecting him/her has been made by the MEC regarding those matters enumerated in

Section 8.2-2. The affected Practitioner shall be entitled to a hearing before the Board takes final action unfavorable to the Practitioner regarding those matters set forth in Section 8.2-2.

8.2 THE HEARING

8.2-1 NOTICE OF ADVERSE ACTION/RECOMMENDATION:

A. When a recommendation is made or action is proposed to be taken which, according to this Credentials Manual entitles a Practitioner to a hearing, the Practitioner shall promptly be given notice by the CEO. This notice shall contain:

(1) a statement of the nature of and reasons for the adverse action or recommendation sufficient to apprise the Practitioner of the general nature of the issues;

(2) notice that the Practitioner has the right to request a hearing on the recommendation within thirty (30) days of his/her receipt of the notice and that any request for a hearing must be in writing and submitted to the CEO;

(3) notice that in the event the Practitioner does not request a hearing in writing within the time and in the manner hereinabove set forth, he/she shall be deemed to have waived his/her right to such hearing and to appellate review and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action;

(4) a summary of the rights at the hearing as outlined in herein; and,

(5) a statement that after receipt of a timely request for a hearing, the Practitioner will be notified of the date, time and place of the hearing after the hearing is set.

B. The Practitioner shall have thirty (30) days following the date of the receipt of the notice within which to request a hearing by the Hearing Panel hereinafter referred to. Said request shall be made by written notice to the CEO. In the event the Practitioner does not request a hearing in writing within the time and in the manner hereinabove set forth, he/she shall be deemed to have waived his/her right to such hearing and to appellate review and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

8.2-2 **GROUNDS FOR HEARING:** No recommendation or action of MEC or Board other than those hereinafter enumerated shall constitute grounds for a hearing:

A. Denial of initial Medical Staff appointment;

B. Denial of requested advancement in Medical Staff category;

C. Denial of Medical Staff reappointment;

D. Revocation of Medical Staff appointment;

E. Denial of requested initial Clinical Privileges;

F. Denial of requested increased Clinical Privileges;

G. Decrease of Clinical Privileges;

H. Suspension, other than automatic or investigatory suspension, of Clinical Privileges;

I. Imposition of a requirement for retraining or additional training that causes the Practitioner to cease his/her practice at the Hospital during the period of retraining;

J. Denial of a request for reinstatement as authorized in Section 7.2; and

K. Imposition of mandatory concurring consultation requirement.

8.2-3 **NON-ADVERSE RECOMMENDATIONS OR ACTIONS:** An automatic denial, suspension, termination, expiration or resignation due to failure to meet an administrative qualification or requirement or a time requirement shall not be deemed adverse and the Practitioner shall not be entitled to the procedural rights outlined in this Article VIII. Some examples of non-adverse actions or recommendations include, but are not limited to:

A. Voluntary resignation of or withdrawal of an application for appointment or for reappointment of Medical Staff appointment and/or Clinical Privileges;

B. Failure to meet established qualifications for Medical Staff appointment or Clinical Privileges; e.g., minimum patient contacts, Board certification, etc;

C. Automatic suspension as outlined in this Credentials Manual;

D. Consultation requirements;

E. Requirements for additional training and or education requirements that do not cause the Practitioner to cease his/her Hospital practice during the training period;

F. Imposition of specified or intensified review, including, but not limited to intensified concurrent or retrospective review;

G. Observation requirements;

H. Assignment of quality appraisal levels in the professional/peer review processes and the action taken by the Practitioner's Committee or other professional review Committee, other than the MEC, as a result thereof, which action does not constitute "adverse action" as outlined above;

I. Actions taken pursuant to the SLV Regional Medical Center Physician/Allied Health Staff Policy Regarding Disruptive Conduct; Routine professional/peer review and routine corrective or peer counseling, whether conducted by or through the Committee or other professional/peer review Committee or otherwise; and

J. Administrative actions or other actions or recommendations deemed not to be adverse by the MEC President in consultation with CEO.

8.2-4 **NOTICE OF HEARING AND STATEMENT OF REASON:** The CEO shall schedule the hearing and shall give notice of its time, place and date, in writing, to the Practitioner. The notice shall also include a list of witnesses, if known, who will give testimony or evidence in support of the MEC or the Board, as applicable, at the hearing. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties. This notice shall contain a statement of the reasons for the recommendation and/or action as well as the list of patient records supporting the recommendation and/or action. This statement, and the list of supporting patient record numbers and other information it contains, may be amended or added to at any time, even during the hearing, so long as the additional material is relevant as determined by the Hearing Officer or Presiding Officer to the continued appointment or Clinical Privileges of the Practitioner requesting the hearing.

8.2-5 **LIST OF WITNESSES:** A written list of the names of the individuals so far as is then reasonably known, who may give testimony or evidence in support of the MEC or the Board at the hearing, shall be given with the notice of hearing. The Practitioner requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his/her behalf within ten (10) days after receiving notice of the hearing.

8.2-6 **HEARING PANEL OR OFFICER:**

A. When a hearing is requested, the MEC President in consultation with the CEO shall appoint a Hearing Panel, which shall be composed of not less than three (3) members. The majority of the Hearing Panel shall be composed of Medical Staff appointees who practice the same profession (physicians, dentists, as applicable) and who did not actively participate in the consideration of the matter involved at any previous level or of physicians not connected with the Hospital or a combination of such

persons. The Hearing Panel shall not include any individual who is in direct economic competition with the affected person, as determined by the Hospital, or any such individual who is professionally associated with or related to the Practitioner. However, at the discretion of the MEC President, at least one (1) member of the Hearing Panel may be an individual with expertise in the same clinical area as the Practitioner. Such appointment shall include designation of the Presiding Officer. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

B. As an alternative to the Hearing Panel described in paragraph A of this Section, the MEC President, after consulting with the CEO may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer shall preferably be an attorney at law or some other individual capable of conducting the hearing. The Hearing Officer may not be any individual who is in direct economic competition with the Practitioner requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

C. The Hearing Panel has the authority to establish the rules and requirements of the Hearing, in addition to the processes outlined in this Article VIII and to decide prehearing objections and requests.

8.2-7 **PRE-HEARING DISCOVERY AND CONFERENCE:**

A. There is no right to discovery in connection with the hearing. Any documents or oral evidence disclosed in the investigation stage shall be maintained confidential and shall not be disclosed or used unless such disclosure or use is mandated by state or federal law.

Prior to the hearing, on dates set by the Presiding Officer, or as agreed upon by the parties, each party shall provide the other party with a list of proposed exhibits, excluding rebuttal exhibits. The exhibit list may be amended and must be provided to the other parties as established by the Presiding Officer or as agreed upon by the parties. All objections to exhibits, to the extent then reasonably known, shall be submitted in advance of the hearing, on or before the date established as outlined above.

The Presiding Officer shall not entertain subsequent objections, except to rebuttal exhibits, unless the other party demonstrates good cause for his/her failure to object as outlined herein, as determined by the Presiding Officer.

B. The Presiding Officer may require the parties and their representatives to participate in a pre-hearing conference for purposes of resolving procedural questions in advance of the hearing.

Either the Presiding Officer or the Hearing Panel shall attend, participate in and rule on matters presented at the pre-hearing conference, as determined in the sole discretion of the Presiding Officer. More than one pre-hearing conference may be required if the composition of the Hearing Panel is changed as a result of a party's objection or as otherwise required by the Presiding Officer.

8.2-8 **FAILURE TO APPEAR:** In the event that, without good cause, the Practitioner requesting the hearing fails to appear and proceed at the pre-hearing conference or the hearing, he/she shall be deemed to have waived his/her right to such hearing and to appellate review and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

8.2-9 **POSTPONEMENTS AND EXTENSIONS:** Postponements and extensions of time beyond any time limit set forth in this Credentials Manual may be requested by anyone but shall be permitted only by the Hearing Panel, its Presiding Officer or the entity that appointed the Hearing Panel on a showing of good cause.

8.2-10 **DELIBERATIONS AND RECOMMENDATION OF THE HEARING PANEL:** After the close of the hearing and receipt of all information requested by the Hearing Panel, the Hearing Panel shall conduct its deliberations outside the presence of any other person, except its legal counsel, if any, and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons supporting the recommendation made and shall deliver such report to the CEO.

8.2-11 **NOTICE AND DISPOSITION OF HEARING PANEL REPORT:** Within a reasonable period of time after receipt of the Hearing Panel report and recommendation, the CEO shall notify the Practitioner who requested the hearing of the findings and recommendations of the Hearing Panel within ten (10) working days if possible. If the hearing has been conducted by reason of an adverse recommendation by the MEC, the CEO shall deliver a copy of the report of the Hearing Panel to the MEC. The MEC shall have the opportunity, if it chooses, to submit a report which will accompany the Hearing Panel's recommendation when the matter is addressed in appellate review to the Governing Board. The MEC's report may offer comments, insights, and further recommendations regarding the Hearing Panel's report. The CEO shall maintain the hearing record, all documentation considered by the Hearing Panel and the report and recommendation of the Hearing Panel.

8.2-12 **EFFECT OF HEARING PANEL REPORT AND RECOMMENDATIONS:**

A. **Unfavorable Findings and Recommendations of the Hearing Panel:** If the recommendations of the Hearing Panel are unfavorable to the Practitioner who requested the hearing, the notice sent by the CEO to the Practitioner shall advise him/her of his/her right to an appeal, the time period and requirements for submitting a request for an appeal, state that failure to request an appeal within the specified time period shall constitute a waiver of the right to appellate review, and all other rights to which he/she may have otherwise been entitled, and state that after receipt of a timely request for an appeal, the Practitioner will be notified of the date, time and place of the appeal.

B. **Favorable Findings and Recommendations of the Hearing Panel:** If the Hearing Panel's recommendations are favorable to the Practitioner who requested the hearing, the CEO shall promptly forward the Hearing Panel report and recommendations, together with all supporting documentation, to the Board for final action. The Board shall take action thereon by adopting or rejecting the Hearing Panel's recommendations in whole or in part, or by referring the matter back to the Hearing Panel for further consideration. Any such referral shall state the reasons therefore, set a time limit within which a subsequent recommendation should be made to the Board, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. As soon as practicable after receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The CEO shall promptly send the Practitioner who requested the hearing notice informing him/her of the action taken by the Board. Favorable action by the Board shall be effective as the final action, and the matter shall be considered finally closed unless either party requests clarification of the Board's decision, or requests reconsideration based upon new evidence that was not available at the time of the Hearing Panel's recommendation. The Board shall decide in its sole discretion whether to grant or deny any request for clarification or reconsideration in light of new evidence offered. Any request for reconsideration based upon new evidence must be made within ten (10) working days of the receipt of notice of the Board action. The standard and process for reconsideration of new evidence shall be as outlined in Section 8.4-4 B. If the Board's action is unfavorable to the Practitioner who requested the hearing, the notice shall inform him/her of his/her right to request an appeal, if it has not been previously exercised or waived.

8.3 **HEARING PROCEDURE**

8.3-1 **REPRESENTATION:** The Practitioner requesting the hearing shall be entitled to be represented at the hearing by an attorney or other representative of his/her choice. He/she shall inform the CEO in writing of the name of his/her attorney or

representative at least ten (10) days prior to the date of the hearing. The MEC or Board whose actions and/or recommendations gave rise to the hearing may also be represented by an attorney or other representative of its choice, as determined in consultation with the CEO. The Hearing Panel may also be represented by an attorney.

8.3-2 **PRESIDING OFFICER:**

A. The CEO may appoint an attorney as Presiding Officer. He/she must not act as prosecuting officer, or as an advocate for either side at the hearing. He/she may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations. He/she may thereafter continue to advise the Board on the matter.

B. The Presiding Officer of the Hearing Panel if not an attorney appointed pursuant to paragraph A. above, shall be entitled to vote as a panel member.

C. The Presiding Officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. The Presiding Officer shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with this Credentials Manual, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence, upon which he/she may be advised by legal counsel. In all instances the Presiding Officer shall act in such a way that all information relevant to the continued appointment or Clinical Privileges of the Practitioner requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the Presiding Officer is acting at all times to see that relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Board.

8.3-3 **RECORD OF HEARING:** A record of the hearing shall be made by use of a court reporter or an electronic recording unit, as determined by the CEO. The cost of such court reporter or electronic recording unit shall be borne by the Hospital, but copies of the transcript may be provided to the Practitioner requesting the hearing at that Practitioner's expense upon the written request of the Practitioner and only if such information is not confidential, privileged or otherwise protected from disclosure under state or federal law.

8.3-4 **RIGHTS OF BOTH SIDES:** At a hearing, both sides shall have the following rights: to be represented by an attorney or other individual of the party's choice, to call, examine and cross-examine witnesses, to present evidence determined to be relevant by the Presiding Officer regardless of its admissibility in a court of

law, to impeach any witness, to rebut any evidence and to submit written statements at the close of the Hearing, which shall be part of the Hearing Record. If the Practitioner requesting the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

8.3-5 **ADMISSIBILITY OF EVIDENCE:** The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any evidence deemed relevant in the discretion of the Presiding Officer shall be admitted, regardless of the admissibility of such evidence in a court of law. The Hearing Panel may question the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

8.3-6 **OFFICIAL NOTICE:** The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

8.3-7 **BURDEN OF PROOF:** At any hearing conducted under this Article, the following rules governing the burden of proof shall apply:

A. The Board or the MEC, depending on whose recommendation or action prompted the hearing initially, shall first come forward with evidence in support of its recommendation or action. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in support of his/her challenge to the recommendation or action.

B. After the evidence has been submitted by both sides, the Hearing Panel may affirm the recommendation of the MEC or the Board unless it finds that the Practitioner who requested the hearing has proved that the recommendation or action that prompted the hearing was not supported by evidence then available and was not supported by evidence presented at the hearing. The Hearing Panel may also modify the recommendation of the MEC or Board but may not expand any proposed unfavorable recommendation or action.

8.3-8 **PRESENCE OF HEARING PANEL MEMBERS AND VOTE:** A majority of the Hearing Panel must be present throughout the hearing and deliberations. If a Panel member is absent from any part of the proceedings he/she shall not be permitted to participate in the deliberations or the decision.

8.3-9 **ADJOURNMENT AND CONCLUSION:** The Presiding Officer may adjourn the hearing and reconvene at the convenience of the participants. Upon

conclusion of the presentation of oral and written evidence, the hearing shall be closed. However, the Hearing Panel may request additional information from the parties. Upon conclusion of its deliberations, which are conducted outside the presence of the parties, and submission of its report and recommendations, the hearing shall be finally adjourned.

8.4 APPEAL

8.4-1 **TIME FOR APPEAL:** Within ten (10) days after the Practitioner is notified of an adverse recommendation from the Hearing Panel, or an adverse recommendation from the Board modifying a recommendation of a Hearing Panel which was favorable to the affected Practitioner, he/she may request an appellate review. The request shall be in writing, and shall be delivered to the CEO, either in person or by certified mail, and shall include a specific statement of the reasons and grounds for appeal and the specific issues he/she wishes to be considered at the appellate review. If such appellate review is not requested within ten (10) days as provided herein, the affected Practitioner shall be deemed to have accepted the adverse recommendation of the Hearing Panel and the right to appellate review will be deemed waived and the recommendation of the Hearing Panel or the Board shall be forwarded to the Board for final action.

8.4-2 **GROUNDS FOR APPEAL:** The grounds for appeal from an adverse recommendation of the Hearing Panel or the Board, as applicable, shall be that:

A. There was substantial failure on the part of the Hearing Panel or Board, whichever recommendation is the subject of the appellate review, to substantially comply with the processes outlined in this Credentials Manual in the matter that was the subject of the hearing so as to deny a fair hearing; or

B. The recommendations of the Hearing Panel or Board, as applicable, are not supported by any evidence contained in the Hearing Record.

8.4-3 **TIME, PLACE AND NOTICE:** Whenever a timely and appropriate request for an appellate review is received, the Chairperson of the Board shall schedule and arrange for an appellate review. The Board shall cause the Practitioner to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than ten (10) days from the date of receipt of the request for appellate review, unless the parties otherwise agree in writing. The Chairperson of the Board for good cause may extend the time for appellate review.

8.4-4 **NATURE OF APPELLATE REVIEW:**

A. The Chairperson of the Board may appoint an Appeal Committee composed of not less than three persons who are members of the Board. Independent third parties designated by the Board in its sole discretion may also participate in or conduct the appeal. At the time of its

appointment, the Appeal Committee shall be given a copy of the Hearing Panel and Board's report and recommendations, as applicable and all supporting documentation.

B. The Appeal Committee may accept new oral or written evidence subject to the same rights of cross-examination or confrontation provided at the hearing. Such additional evidence may be accepted only if the party seeking to admit it can demonstrate that the oral or written evidence was not available at the hearing and then only at the discretion of the Appeal Committee.

C. Each party shall have the right to present a written statement in support of its position on appeal prior to or at the appellate review, and each party or its representative may appear personally and make oral argument.

8.4-5 **FINAL DECISION OF THE BOARD:** If the Appeal Committee is composed solely of Board members, the decision of the Appeal Committee shall be final action of the Board and the recommendation shall not be presented to the Board for action. If the Appeal Committee includes third parties who are not members of the Board, the Appeal Committee shall, within thirty (30) days after the appellate review is closed, submit the Appeal Committee's recommendation to the Board. The recommendation of the Appeal Committee may be considered at the next regular meeting of the Board and the Board shall take final action thereon. The Board may affirm, modify or reverse the recommendation of the Appeal Committee, or in its discretion, refer the matter for further review and recommendation. The CEO shall also notify the Practitioner and MEC of the final action of the Board.

8.4-6 **FURTHER REVIEW:** Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board.

8.4-7 **RIGHT TO ONE HEARING AND APPEAL ONLY:** No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one hearing and one appellate review on any single matter.

ARTICLE IX: GENERAL PROVISIONS

9.1 **ADDITIONAL RULES**: There may be additional policies, procedures, rules, regulations, guidelines and requirements which apply to such Medical Staff appointees and it is each Medical Staff appointee's responsibility to obtain, read, understand and abide by all bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and the Medical Staff Documents. The Medical Staff Office

of the Hospital will make reasonable efforts to provide members of the Medical Staff with notice regarding changes in such above-referenced additional rules.

9.2 **PROFESSIONAL REVIEW:** The appointment and reappointment processes, the investigation and corrective action processes, the hearing and appellate review processes and all other processes outlined in this Credentials Manual and all other bylaws, policies, procedures, rules, regulations, guidelines, manuals and requirements of the Hospital and the Medical Staff Documents and/or undertaken by or delegated to the Medical Staff in which the professional practice skills, qualifications, competency, clinical services, quality of medical care provided, efficiency of medical care provided and/or professional conduct of an applicant to or appointee of the Medical Staff is reviewed, evaluated and/or reported on and/or a recommendation is made or action taken are part of the professional/peer review processes at the Hospital. All of the immunities, protection and privileges available under state and/or federal law are intended to apply to professional/peer review processes at the Hospital.

ARTICLE X: ANNUAL REVIEW, ADOPTION AND AMENDMENT

10.1 **ANNUAL REVIEW:** the MEC will review this Credentials Manual on an annual basis. The Medical Staff shall recommend any revisions it deems appropriate to the Board.

10.2 **METHOD OF ADOPTION, AMENDMENT AND REPEAL:** This Credentials Manual may be adopted, amended or repealed by the following action:

10.2-1 **ADOPTION AND REPEAL:** This Credentials Manual may be adopted only by affirmative action of the Board. This Credentials Manual is effective when adopted by the Board, but is subject to the approval by the Medical Staff.

10.2-2 **REPEAL:** This Manual may be repealed, in whole or in part, only by action of the Medical Staff and approval by the Board, except as provided in Section 10.2-3. At least thirty days prior to a vote by the Medical Staff on any action to repeal this Credentials Manual, the Medical Staff must advise the Board of the upcoming vote.

10.2-3 **AMENDMENT:** Once adopted, either the Medical Staff or the Board may amend this Credentials Manual. Such amendments are effective when approved by the other body. If significant changes are made to this Credentials Manual, those who have Medical Staff membership or Clinical Privileges will be provided copies of the revised texts, which will be available for review at the Medical Staff Office of the Hospital.

10.2-4 **CORRECTIONS:** The Medical Staff may correct typographical, spelling or other obvious errors in this Credentials Manual. The Medical Staff, with Board approval, may also make any changes specifically required by law, state or federal statues.

APPROVED by the MEC on July 13, 2005

Medical Executive Committee President

APPROVED by the Board on July 27, 2005

Calvin Hazedon

SLV Regional Medical Center Board President