APPENDIX B - Credentials Procedures Manual

For Lincoln Count Medical Center’s Medical & Dental Staff Bylaws

Approved by Lincoln County Medical Center Board of Trustees

February 18, 2025

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1 Authority and Interpretation

1.1 Authority

This Credentials Procedures supplements the Medical Staff Bylaws, and in particular, Article II of the Medical Staff Bylaws, Medical Staff Categories and Credentialing Process.

1.2 Interpretation

To promote continuity and uniformity throughout the hospitals owned by Presbyterian Healthcare Services (PHS), this Credentials Procedures Manual reflects the overarching philosophies and practices of PHS, including those included in its corporate bylaws. Subject to the authority and approval of the facility boards, this manual is designed to be interpreted consistent with such philosophies and practices, including the policies and procedures of PHS as applied to its individual hospitals. Additionally, this manual has been written to provide flexibility, where appropriate, to each PHS hospital, taking into consideration the size of the hospital and its medical staff and the types of services offered. Examples include the definition of credentialing authority and the electronic voting process for Tract 1 and Tract 2 applications.

2 Definitions

2.1 Advance Practice Clinician or APC

Means the types of Practitioners defined in the Bylaws.

2.2 Credentialing Authority

Means the governing board and the following groups or individuals who are involved in the credentialing review and approval process, and as the context requires:

a. Designated board members (not less than two) to whom the governing board has delegated credentialing oversight

b. The credentials committee,

c. The credentials committee chair

d. Other credentials committee members acting on behalf of the credentials committee

e. Medical staff department service chairs

f. The Chief Medical Officer

g. The Director of Medical Staff Affairs

h. The President of the Medical Staff

i. Any other individual officer or executive who fulfills the role of the officers and executives identified above, regardless of title

j. For verification purposes only, the Central Verification Office

k. Third party entities to which PHS has entered into a delegated credentialing contract

2.3 Credentialing Process

Means any program or proceeding utilized by the hospital to assess, review, study, or evaluate the credentials of a health care practitioner with regard to initial and continued medical staff membership or appointment and granting of clinical privileges.

2.4 Governing Board or Board

Means the governing body of the hospital.

2.5 Hospital

Means a hospital within the Presbyterian Healthcare Services, specifically Lincoln County Medical Center.

2.6 Patient Encounter

Means an inpatient admission, inpatient encounter, clinic visit, inpatient or outpatient surgical procedure, or an ED call shift.

2.7 Professional Review Action

Professional Review Action means an investigation and resulting proceeding against a physician on the medical staff that is reportable to the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 and its successor statues, and any applicable state reporting requirements, that is related specifically to clinical incompetence or misconduct that adversely affects clinical privileges for greater than thirty (30) calendar days (e.g., denial of appointment and/or reappointment; reduction in clinical privileges) or a resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation that could result in a decision which adversely affects clinical privileges for greater than thirty (30) days.

Peer review activities are those involving the evaluation of the professional judgment, skill or behavior of medical staff members and fall under New Mexico's Review Organization Immunity Act ("ROIA"). ROIA, in turn, involves strict confidentiality of opinions, observations and evaluations on a need-to-know basis. PHS medical staff bylaws provide for both "informal" and "formal" mechanisms to address issues, incidents or patterns of action, inaction or behavior of medical staff members. Peer review activities are generally conducted in a peer review committee setting but can also include individual case reviews, interactions, interviews or other activities that contribute to the evaluation of the professional judgment, skill or behavior or medical staff members. Thus peer review is not limited solely to "peer reviewed cases".

2.8 Telemedicine

Means the mode of delivering healthcare services to patients by physicians and other licensed practitioners from a distance through the use of telecommunication technologies where the patient and healthcare provider delivering the services are at different physical locations.

2.9 Telemedicine Technologies

Means telemedicine communications using either synchronous and asynchronous communication, video conferencing, virtual clinical-patient encounters, transmission of still images, e-health including patient portals, remote monitoring of patient conditions, e-

consultations, continuing medical education and nursing call centers.

2.10 Telemedicine Distant-Site Provider

Means the hospital or healthcare provider that uses a practitioner or specialist to provide health care services via a telecommunications system to hospital patients located at another location or remote site and may sometimes be referred to as the remote, hub, specialty or consulting site.

2.11 Telemedicine Patient Site

Means the hospital or other healthcare location where the practitioner delivering the service is located at the time the service is provided by a telecommunications system and may sometimes be referred to as the originating, remote, or distant site.

3 Medical Staff Credentials Committee

3.1 Composition

If the hospital utilizes a credentials committee that is composed separately from the MEC, the medical staff credentials committee shall consist of a reasonable number of active medical staff who are experienced leaders. To avoid even the appearance of bias, such members should not, to the extent possible, concurrently hold a medical staff leadership role over a service line or division/department. The president of the medical staff will appoint the chair and other members. The chair will be appointed after consultation with the Director of Medical Staff Affairs and ratified by the MEC.

3.2 Term; Removal

Members will be appointed for three-year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The chair will also be appointed for a three-year term. The chair may be appointed for two successive terms, to serve a total of six years unless the MEC grants an exception to permit additional service; the other members may be reappointed for additional terms without limit. Any member, including the chair, may be relieved of their committee membership by a two-thirds (2/3) vote of the MEC. The committee may also invite members such as representatives from hospital administration and the Board.

3.3 Meetings and Voting

The medical staff credentials committee shall meet monthly and may also meet on call of the chair or president of the medical staff. Meetings may be via electronic means. Additionally, committee responsibilities, including but not limited to, voting on applications, reapplications, privileges, eligibility criteria, and policies and procedures, may be completed whenever possible without the necessity of an in person meeting or meeting via electronic means as long as items are communicated via a secure data room or similar method and votes are logged via secure electronic communications in accordance with voting and quorum requirements.

3.4 Responsibilities

The credentials committee has the following responsibilities:

3.4.1 **Appointment**. To review and recommend action on all applications and reapplications for membership on the medical staff including assignments of medical staff category;

3.4.2 **Privileges.** To review and recommend action on all requests regarding privileges from eligible practitioners;

3.4.3 **Criteria**. To recommend eligibility criteria for the granting of medical staff membership and privileges;

3.4.4 **Related Policies and Procedures**. To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

3.4.5 **Action on Referrals and Reports**. To review, and where appropriate take action on, reports that are referred to it from other medical staff committees, medical staff or hospital leaders; and

3.4.6 **Other Duties**. To perform such other functions as requested by the MEC.

3.5 Peer Review Committee.

This committee shall function as a peer review committee consistent with federal and state law, including but not limited to ROIA. All members of the committee shall, consistent with the medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee. All committees and individuals who provide information for consideration by the peer review committee shall be entitled to the full extent of privileges and immunities permitted by applicable law, including but not limited to ROIA.

4 Confidentiality

4.1 Credentials Committee.

The credentials committee and Credentialing Authority shall, consistent with medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of the Credentialing Process.

4.2 Credentials Files.

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

4.3 Practitioner Review.

Individual practitioners may review their own credentials file only upon written request approved by the Credentialing Authority. Review of such files will be conducted in the presence of the medical staff service professional, medical staff leader, or another designee of administration. Nothing may be removed from or copied from the file although the practitioner may make notes for inclusion in the file upon approval by president of the medical staff, hospital administrator, credentials chair or chief medical officer. Confidential letters of reference and other documents written by others about the practitioner but not previously provided to the practitioner may not be reviewed by practitioner. These documents will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

5 Qualifications for Membership and/or Privileges

5.1 Verification Requirements. The following qualifications must be met by all applicants for medical staff appointment, reappointment or clinical privileges. All practitioners appointed to the medical staff or granted clinical privileges at the hospital have an ongoing, affirmative obligation to immediately notify the proper credentialing authority of any change in status that would result in the practitioner no longer meeting these requirements.

5.1.1 Education. Demonstrate that they have successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry or applicable recognized course of training in a clinical profession eligible to hold privileges;

a. Education – Psychologist or Psychiatrist. A psychologist must have an earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and be board certified as appropriate to the area of clinical practice;

b. Education – Dentists. Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

5.1.2 License. Have a current state or federal license as a practitioner, applicable to their profession, and providing permission to practice within the state of New Mexico;

5.1.3 No Sanctions. Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities;

5.1.4 Felony Convictions. Have a record that is free of felony convictions within the last five (5) years;

5.1.5 Residency and Board Certification. A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and achieve, or be eligible for, board certification as defined by the appropriate division and approved by the MEC.

a. Residency and Board Certification – Oral and Maxillofacial Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;

b. Residency and Board Certification - Podiatric A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine;

c. Residency and Board Certification – Psychologist A psychologist must have completed at least two (2) years of clinical experience in an organized healthcare

setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and be board certified as appropriate to the area of clinical practice;

5.1.6 DEA. Possess a current, valid, drug enforcement administration (DEA) number and New Mexico Controlled Substance Registration if applicable;

5.1.7 Communication. Have appropriate written and verbal communication skills;

5.1.8 Ethical and Professional Standards. Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. No Illegal Payment. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

b. Professionalism. A history of consistently acting in a professional, appropriate and collegial manner with others in previous clinical and professional settings.

5.2 Clinical Requirements. The following clinical qualifications must also be met by all applicants requesting medical staff appointment, reappointment or clinical privileges:

5.2.1 Clinical Competence. Demonstrate their background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

5.2.2 Physical and Mental Health. Provide proof of a physical and mental health checkup with a primary care physician, or when requested by the MEC or Medical Director of Medical Staff affairs during appointment, reappointment or between reappointment cycles, a more focused examination (including but not limited to a cognitive evaluation) that the applicant's physical and mental health does not impair, even with reasonable accommodation, the safe fulfillment of their responsibilities of medical staff membership and the specific privileges requested by and granted to the applicant:

a. **Appointment Cycle.** At initial appointment and every other reappointment (i.e., every four (4) years); and

b. **Upon Request**. Upon request of the MEC or Medical Director of Medical Staff Affairs between reappointment cycles if deemed advisable;

5.2.3 Continuous and Timely Care. Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

5.2.4 Experience. Demonstrate recent clinical performance as defined by the appropriate division with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

5.2.5 Professional Liability. Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

5.3 Exceptions As provided elsewhere related to disaster and emergency the MEC may create additional exceptions to the above as approved by board resolution .

6 Application Process

6.1 Application Request. All requests for applications for appointment to the medical staff and requests for clinical privileges will be forwarded to the medical staff office or other designated place. Upon receipt of the request, the medical staff office will provide the applicant an application package.

6.2 Applicant's Attestation, Authorization and Acknowledgement. The applicant must complete and sign the application form. By signing the application, the applicant:

6.2.1 Attests Accuracy. Attests to the accuracy and completeness of all information on the application or accompanying documents and agrees that any substantiative inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

6.2.2 Interviews. Consents to appear for any requested interviews in regard to their application.

6.2.3 Peer References. Authorizes the hospital and medical staff representatives to consult with prior and current associates and others who may have information bearing on their professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

6.2.4 Record Review. Consents to hospital and medical staff representatives' inspection of all records and documents that may be material to an evaluation of:

a. Professional qualifications and competence to carry out the clinical privileges requested;

b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;

c. Professional and ethical qualifications;

d. Professional liability actions including currently pending claims involving the applicant; and

e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

6.2.5 Release of Liability. Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to the hospital representatives concerning their background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

6.2.6 Release of Information. Authorizes the hospital medical staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, medical associations, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment or other matters relevant to the determination of the applicant's overall qualifications upon

appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits or challenges against any medical staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.

6.2.7 Compliance. Acknowledges that the applicant has had access to the medical staff bylaws, including all rules, regulations, policies and procedures of the medical staff and agrees to abide by their provisions.

6.2.8 Licensure Status. Agrees to provide accurate answers to the questions on the New Mexico Uniform Statewide Application, and agrees to immediately notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's medical staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

6.3 Information Burden. The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested. Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the medical staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn. The 45- day deadline may be extended by the credentialing authority for good reason.

6.4 Completed Application. A completed application includes, at a minimum:

6.4.1 Application Form. A completed, signed, dated application form;

6.4.2 Privilege Delineation Form. A completed privilege delineation form if requesting privileges;

6.4.3 Supporting Documentation. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;

6.4.4 Fees. All applicable fees, if any;

6.4.5 Identification. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card;

6.4.6 References. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested;

6.4.7 Practitioner Data. Relevant practitioner-specific data as compared to aggregate data, when available; and

6.4.8 Consents. Signed general and specific consents to enable the Credentialing Authority to process, verify, review and discuss the application and releases to hold the Credentialing

Authority harmless from liability associated with credentialing and privileges actions undertaken in good faith on behalf of the hospital medical staff and board .

6.5 Incomplete Application. An application shall be deemed incomplete if any of the items required for a completed application are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application and such information is not provided. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Failure to execute the consents and releases required for a completed application shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further .

6.6 Eligibility Threshold. Upon receipt of a completed application the Credentialing Authority will determine if the requirements of the above sections are met. In the event the requirements of the above sections are not met, the potential applicant will be notified that they are ineligible to apply for membership or privileges on the medical staff, the application will not be processed and the applicant will not be eligible for a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken. If the eligibility requirements are met, the application will be accepted for further processing

6.7 Verification. Upon receipt of a completed application, the medical staff office or designee will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office or designee will collect relevant additional information which may include:

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

6.7.2 Work Experience. Documentation of the applicant's past clinical work experience;

6.7.3 Licensure. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the medical staff office or designee will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

6.7.4 Exclusions. Information, at a minimum, from the AMA or AOA Physician Profile, OIG list of Excluded Individuals/Entities, and EPLS.

6.7.5 Residency. Information from professional training programs including residency and fellowship programs;

6.7.6 NPDB. Information from the National Practitioner Data Bank (NPDB); in addition the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;

6.7.7 Adverse Actions. Other information about adverse credentialing and privileging decisions;

6.7.8 Peer References. Two or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges;

6.7.9 **Background Check.** Information from a lifetime criminal background check ;

6.7.10 **Other Information**. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges;

6.7.11 **M&M Data**. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available; and

6.7.12 **Testing Results**. If available and not legally protected, the results of any drug testing and/or other health testing required by a health care institution or licensing board.

Note: In the event there is undue delay in obtaining required information, the medical staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five (45) calendar days will be deemed a withdrawal of the application.

6.8 **Verified, Completed Application**. When the items required for verification have been obtained and the information in the application has been confirmed, the file will be considered verified and complete and eligible for evaluation.

7 Evaluation of Completed, Verified Applications

7.1 **Credentialing**: All initial completed, verified applications for membership and/or privileges will be designated Track 1, Track 2, or Track 3 by the appropriate service chair who then will forward their recommendation as delineated below to the appropriate credentialing authority. At any point in the process, a Track 1 or Track 3 application can be reassigned to the Track 2 process. No credentialing authority is required to adopt the recommendations of the prior credentialing authority reviewing the application but may make different recommendations, and in the case of the governing body, approve, deny, or otherwise limit an applicant's request for appointment, reappointment, medical staff membership, and clinical privileges.

7.2 **Track Process.** The different consideration and process for each track are as follows:

Track 1: A completed and verified application that does not raise concerns which warrant additional review is eligible for Tract 1. Applicants in Track 1 may be granted medical staff membership and/or privileges after review and action by the designated Credentialing Authority.

Track 2: A completed and verified application that raises one or more concerns which warrant additional review will follow the Tract 2 process. Applications in Track 2 must be reviewed and acted on by any applicable division chief, the credentials committee, MEC, and the Board. The credentials committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that they meet the criteria for membership on the medical staff and for the granting of requested privileges.

Track 3. Track 3 is available for FPPE – Training privileges only and is reserved for completed and verified applications that do not raise concerns which warrant additional review. Applicants in Track 3 may be granted FPPE – Training privileges after review and action by the designated Credentialing Authority.

7.3 **Track 2 Criteria Further Defined**. Criteria for Track 2 applications include but are not necessarily limited to the following:

7.3.1 **Additional Review Deemed Incomplete**. The application is deemed to be incomplete

upon further review and requires additional clarifying information to before it can be appropriately considered;

7.3.2 Adverse or Limited Recommendation. The final recommendation of the MEC is adverse or with limitation;

7.3.3 Questions. Questions develop through the review process;

7.3.4 Loss of Privileges. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;

7.3.5 Investigation. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

7.3.6 Pattern of Cases. Initial applicant has had 2 or more, or an unusual pattern, or excessive number of malpractice cases filed within the past five (5) years. For reappointment applicants, one or more, or unusual pattern of malpractice cases filed within the past reappointment cycle. Unusual pattern to be determined by the appropriate division chief.

7.3.7 References. Applicant has one or more reference responses that raise concerns or questions

7.3.8 Discrepancy. There is a discrepancy between the information received from the applicant and references, or verified information.

7.3.9 Unreasonable. The request for privileges is not reasonable based upon the applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria (requires comment from division chief or other equivalent Credentialing Authority)

7.3.10 Managed Care Removal. Applicant has been removed from a managed care panel for reasons of professional conduct or quality

7.3.11 NPDB Report. Applicant has an adverse National Practitioner Data Bank report;

7.3.12 Wellness. Applicant has potentially relevant physical, mental and/or emotional health problems;

7.3.13 Practice Concerns. Adverse responses to professional practice questions are listed on the application;

7.3.14 Other. Other reasons as determined by a Credentialing Authority or other representative of the hospital which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges.

7.4 Applicant Interview

7.4.1 Scope. All applicants for appointment to the medical staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Credentialing Authority. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate medical staff performance expectations.

7.4.2 Procedure. The applicant will be notified if an interview is requested. The interview may

take place in person or by telephone at the discretion of the hospital or Credentialing Authority. Failure of the applicant to appear for a scheduled interview will be deemed a withdrawal of the application.

7.5 Division Chief Action/Equivalent Credentialing Authority

7.5.1 Review. All verified, completed applications are presented to the clinical service chair or other equivalent Credentialing Authority for review, and recommendation. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The appropriate Credentialing Authority determines whether the application is forwarded as a Track 1, Track 2 or Track 3. If necessary, the Credentialing Authority may consult an appropriate subject matter expert for input. If a Credentialing Authority believes a conflict of interest exists that might preclude their ability to make an unbiased recommendation, they will notify the next higher Credentialing Authority and forward the application without comment.

7.5.2 Procedure. The clinical service chair or other equivalent Credentialing Authority forwards to the next higher Credentialing Authority the following along with supporting comments:

a. **Track Recommendation.** A recommendation as to whether the application should be acted on as Track 1 Track 2, or Track 3;

b. **Recommendation of Action.** A recommendation to approve the applicant's request to membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

c. **Monitoring Recommendation**. A recommendation to define any circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

7.6 Medical Staff Credentials Committee Action

7.6.1 Review. If the application is designated Track 1, it is presented to the credentials chair or designee for review and recommendation. If the application is designated Track 3, it is presented to the credentials chair's designee, the Chief Medical Officer, for review and recommendation.

7.6.2 Procedure. The credentials chair or other designated credentialing authority reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The credentials chair or other designated credentialing authority has the opportunity to determine whether the application is forwarded as a Track 1 or a Track 3 or may change the designation to a Track 2. If forwarded as a Track 1 or Track 3, the credentials chair or other designated credentialing authority acts on behalf of the medical staff credentials committee and the application is presented to the MEC for review and recommendation. If designated Track 2, the medical staff credentials committee reviews the application and forwards the following to the MEC:

a. **Track Recommendation.** A recommendation as to whether the application should be acted on as Track 1, Track 2 or Track 3 along with supporting comments;

b. **Recommendation of Action**. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

c. **Monitoring Recommendation**. A recommendation to define any circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

7.7 MEC Action

7.7.1 **Review**. If the application is designated Track 1 or Track 3, it is presented to the MEC, which may meet in accordance with quorum requirements established for credentialing.

7.7.2 **Procedure**. The president of the medical staff has the opportunity to determine whether the application is forwarded as a Track 1 or Track 3, or may change the designation to a Track 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board, along with supporting comments:

a. **Track Recommendation.** A recommendation as to whether the application should be acted on as Track 1,Track 2, or Track 3;

b. **Recommendation of Action.** A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

c. **Monitoring Recommendation**. A recommendation to define any circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in these bylaws

7.8 Board Action

7.8.1 **Track 1 or Track 3**. If the application is designated by the MEC as Track 1 or Track 3 it is presented to the Board or an appropriate subcommittee of at least two (2) members, at least one of whom must be a non-physician, where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) calendar months unless applicable laws, regulations, and accreditation standards or policies permit a longer, or mandate a shorter, term. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Track 2 applications will be followed.

7.8.2 **Track 2**. If the application is designated as a Track 2, the Board reviews the application and votes for one of the following actions:

a. **Decision**. The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges, it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) calendar months unless applicable laws, regulations, and accreditation standards or policies permit a longer, or mandate a shorter, term.

b. **Notice of Adverse Action**. If the board's action is adverse to the applicant, a

special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Article III of the bylaws (Investigations, Corrective Actions, Hearings and Appeals Plan) and Appendix C, the Investigations, Corrective Actions, Hearings and Appeals Manual.

c. **Final Action**. The Board shall take final action in the matter as provided in Article III of the bylaws (Investigations, Corrective Actions, Hearings and Appeals Plan) and Appendix C, the Investigations, Corrective Actions, Hearings and Appeals Manual.

7.9 **Notice of final decision**: Notice of the Board's final decision shall be given, through the hospital administrator to the MEC and to the chair of each clinical service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the clinical service to which they are assigned, the clinical privileges they may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

7.10 **Time periods for processing**: All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 120 (one-hundred twenty) calendar days. These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Article III of these bylaws (Investigations, Corrective Actions, Hearings and Appeals Plan) and in Appendix C (Investigations, Corrective Actions, Hearings and Appeals Manual) are activated, the time requirements provided therein govern the continued processing of the application.

8 Professional Practice Evaluation

8.1 **FPPE**. All initially requested privileges shall be subject to a period of focused professional practice evaluation (FPPE). Exclusively for purposes of National Practitioner Data Bank Reporting, neither FPPE nor actions taken solely pursuant to FPPE for newly requested privileges will be considered an adverse professional peer review action.

8.1.1 **Procedure**. The credentials committee, or its designated Credentialing Authority, after receiving a recommendation from the division chief and with the approval of the MEC, will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following their initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentialing Authority will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

8.1.2 **FPPE for Other Practitioners**. Practitioners who do not have newly requested privileges but who may have been identified through OPPE as potentially having concerns related to the provision of safe, quality patient care may also be subject to FPPE.

8.2 **OPPE.** The medical staff will also engage in ongoing professional practice evaluation (OPPE) to identify professional practice trends that affect quality of care and patient safety. OPPE shall be undertaken as part of the medical staff's evaluation, measurement, and improvement of practitioner's current clinical competency and will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the

time of reappointment. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

8.3 **No Professional Review Action**. FPPE and OPPE evaluations are not used as precursors to professional review actions. As such, they are not considered investigations that trigger reporting to the National Practitioner Data Bank.

9 Reappointment

9.1 **Definitions**. For the purpose of reappointment an "adverse recommendation" by the Board means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under the medical staff bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment."

9.2 **Criteria for Reappointment.** It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment. The Credentialing Authority must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program.

9.3 **Duration.** All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) calendar months unless applicable laws, regulations, and accreditation standards or policies permit a longer, or mandate a shorter, term.

9.4 **Procedure**. The granting of new clinical privileges to existing medical staff members will follow the steps described above concerning the initial granting of new clinical privileges and focused professional practice evaluation. The vice-chief shall substitute for the division chief in the evaluation of current competency of the division chief, and recommend appropriate action to the credentials committee.

9.4.1 **Continued Eligibility**. In the event a practitioner finds no need to utilize the facilities or resources of the institution for purposes of patient care through either admission, performance of a procedure, consultation, or referral, during a two-year period, they may not be eligible for reappointment or continued privileges. Such practitioner may apply as a new applicant at any time subsequent to the expiration of current appointment or privileges. This provision applies to individuals who have been granted a leave of absence, moved their practice location, established a relationship with another institution or otherwise find no need to utilize the clinical resources of the institution. Exceptions to this provision may be made by the Board upon recommendation of the MEC.

9.4.2 **Reappointment Information Collection.** On or before four (4) months prior to the date of expiration of a medical staff appointment or grant of privileges, a representative from the medical staff office notifies the practitioner of the date of expiration and supplies them with an application for reappointment for membership and/or privileges.

9.4.3 **Information Required from Practitioner.** At least sixty (60) calendar days prior to the expiration date of current appointment or privileges the practitioner must return the following to the medical staff office:

a. **Updated Form**. A completed reapplication form, which includes complete information to update their file on items listed in their original application, any required new, additional, or clarifying information, and any required fees or dues;

b. **Updated Education**. Information concerning continuing training and education internal and external to the hospital during the preceding period; and

c. **Consent**. By signing the reapplication form the appointee agrees to the same terms as identified for initial appointment and privileges.

9.4.4 **Verification**. The Central Verification Office collects and verifies information regarding each staff appointee's professional and collegial activities as required for initial appointment. The Credentialing Authority also collects and verifies the following:

a. **Clinical Activity**. A summary of clinical activity at this hospital for each appointee due for reappointment;

b. **Clinical Indicators**. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided any clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;

c. **Continuing Education**. Documentation of any required hours of continuing medical education activity;

d. **Medical Staff Service**. Service on medical staff, clinical service, and hospital committees;

e. **Medical Records**. Timely and accurate completion of medical records;

f. **Compliance**. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff;

g. **Gaps**. Any significant gaps in employment or practice since the previous appointment or reappointment;

h. **Licensure.** Verification of current licensure;

i. **NPDB.** National Practitioner Data Bank query;

j. **Peer References**. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges; and

k. **Malpractice**. Malpractice history for the past two (2) years, which is primary source verified by the medical staff office with the practitioner's malpractice carrier(s).

9.4.5 **Additional information and failure to provide**. Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded.

9.4.6 **Review**. Once the information is received, the Credentialing Authority verifies this additional information and notifies the staff appointee of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

9.4.7 Evaluation of Application for Reappointment of Membership and/or Privileges. Review reappointment applications will be categorized and acted upon as Tract 1 or Track 2 based on the factors described for initial appointment. In acting on reappointment applications, the Credentialing Authority will also review other relevant information such as FPPE, OPPE, collegial interventions and inquiries, MEC-directed investigations, automatic terminations, and precautionary suspensions.

10 Medical Staff Categories

The medical staff categories with their qualifications, prerogatives, and responsibilities are detailed below.

10.1 Active Staff

10.1.1 Qualifications. Members of this category must have served on the Associate medical staff for two years and be involved in twelve (12) patient encounters per year. In the event that a member of the active category does not meet the qualifications for reappointment to the active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the medical staff and hospital, the member may be appointed to another medical staff category if they meet the eligibility requirements for such category. Changes in medical staff category will be made at reappointment.

10.1.2 Prerogatives. Active staff may, unless an exception applies:

a. **Meetings**. Attend medical staff, clinical service and division meetings of which they are a member and any medical staff or hospital education programs and social activities;

b. **Voting**. Vote on all matters presented by the medical staff clinical service or division, and committee(s) to which the member is assigned; and

c. **Office**. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

10.1.3 Responsibilities. Active staff shall:

a. **Administrative Affairs**. Contribute to the organizational and administrative affairs of the medical staff;

b. **Activities and Functions**. Actively participate as requested or required in activities and functions of the medical staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion and in the discharge of other staff functions as may be required; and

c. **Compliance**. Fulfill or comply with any applicable medical staff or hospital policies or procedures, including those related to history and physical.

10.2 Associate Staff

10.2.1 Qualifications. The associate category is reserved for practitioners who are pursuing active staff status but who do not yet meet the two-year medical staff eligibility requirement or the patient encounter requirement. Associate category is also reserved for those practitioners who choose not to pursue active staff status.

10.2.2 Prerogatives. Associate staff:

a. **Meetings.** May attend medical staff, clinical service and division meetings of which they are a member and any medical staff or hospital education programs and social activities;

b. **Vote.** May not vote on matters before the entire medical staff or be an officer of the medical staff; and

c. **Committees**. May serve on medical staff committees only if requested, other than the MEC, and may vote on matters that come before such committees.

10.2.3 Responsibilities. Associate staff shall fulfill or comply with any applicable medical staff or hospital policies or procedures, including those related to history and physical.

10.3 Affiliate Staff

10.3.1 Qualifications. Affiliate staff is reserved for members who maintain a clinical practice in the hospital service area and wish to be able to follow the course of their patients when admitted to the hospital.

10.3.2 Prerogatives. Affiliate staff have limited privileges. They may**:**

a. **Visit Patients.** Visit patients in the hospital, review medical records;

b. **Limited Privileges**. Have limited procedural privileges as determined by the Credentialing Authority;

c. **Meetings**. Attend medical staff clinical service and division meetings, CME functions and social events;

d. **Limited Orders and Charting**. Not write orders or chart on more than five (5) patients within a 365-day period, unless otherwise permitted by the Credentialing Authority; and

e. **Vote**. Not vote on medical staff affairs or hold office.

10.3.3 Responsibilities. Affiliate Staff shall fulfill or comply with any applicable medical staff or hospital policies and procedures.

10.4 Honorary Staff

10.4.1 Qualifications. Honorary staff is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Honorary staff shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital.

10.4.2 Prerogatives. Honorary staff have no clinical privileges. They may:

a. **Meetings**. Attend medical staff, clinical service and division meetings;

b. **Education**. Participate in continuing medical education activities;

c. **Committees**. Be appointed to and vote on the committees to which they are appointed; and

d. **Voting and Office**. Not vote on medical staff affairs or hold office.

10.4.3 Responsibilities. Honorary staff shall fulfill or comply with any applicable medical staff or hospital policies and procedures**.**

10.5 Advance Practice Clinician (APC) Staff

10.5.1 Qualifications. APC Staff may be assigned active or associate status with active status being reserved for APCs who have held privileges for the preceding two years and have been involved in twelve (12) patient encounters each year.

10.5.2 Prerogatives – APC Staff with Active Status. APC Staff with an active status designation may:

a. **Meetings.** Attend medical staff, clinical service and division meetings of which they are a member and any medical staff or hospital education programs and social activities;

b. **Vote**s. Vote on all matters presented by the medical staff clinical service or division, and be assigned to and vote on all committee(s) to which the member is assigned;

c. **Officer**. Hold office and sit on or be the chair of committees in accordance with qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff and hospital policies but may not serve as President of the Medical Staff or Chair of a peer review investigation or peer review hearing; and

10.5.3 Prerogatives – APC Staff with Associate Status. APC Staff with an associate status designation may attend medical staff, clinical service and division meetings of which they are a member and any medical staff or hospital education programs and social activities.

10.5.4 Responsibilities. APC Staff, regardless of active or associate status, shall:

a. **Administrative Affairs.** Contribute to the organizational and administrative affairs of the medical staff;

b. **Activities and Functions.** Actively participate as requested or required in activities and functions of the medical staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion and in the discharge of other staff functions as may be required; and

c. **Compliance.** Fulfill or comply with any applicable medical staff or hospital policies or procedures, including those related to history and physical.

11 Privileges

11.1 Scope of Practice. Practitioners providing clinical services at the hospital may exercise only those privileges granted to them by the Board or emergency or disaster privileges as described herein. In addition to the medical staff categories outlined above, practitioners serving short locum tenens positions, telemedicine practitioners, or house staff such as residents moonlighting in the hospital, or others deemed appropriate by the MEC and Board may be granted privileges

11.2 Request. When applicable, each application for appointment or reappointment to the medical staff must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

11.3 Basis for Privileges Determination

11.3.1 Established Criteria. Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board-approved criteria for clinical privileges.

11.3.2 New Criteria. Privileges requests for which no criteria have been established, such as technology or a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC will:

a. **Need Assessment**. Review the community, patient and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;

b. **Viability Review.** Review with members of the credentials committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);

c. **Hospital Mission and Strategic Plan**. Meet with management to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information and staffing plans;

d. **Compliance Review**. Work with management to ensure that any/all exclusive contract issues, if applicable, are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract.

e. **Contracts, Equipment, Clinical Support Staff and Management**. Work with appropriate hospital related administrator and/or department directors to evaluate contractual and equipment, clinical support staff and management needs;

f. **Criteria Formulation**. Upon recommendation from the credentials committee and appropriate clinical service/specialty or subject matter experts (as determined by the credentials committee), formulate the necessary criteria and recommend these to the Board.

i. **Resources**. For the development of criteria, the medical staff service professional (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate.

ii. **Criteria Requirements**. Criteria requirements to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed including who may serve as proctor and how many proctored cases will be required.

iii. **Overlaps.** If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the credentials chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be

a member of the credentials committee who has no vested interest in the issue.

g. **Process Request**. Once objective criteria have been established, the original request will be processed as described herein:

11.4 Standard of Review. Requests for clinical privileges will be consistently evaluated on the basis of:

11.4.1 Clinical Competence. Prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment;

11.4.2 Patient Care Needs and Capacity. Patient care needs, the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence;

11.4.3 Reappointment or Change. For periodic reappointment or a requested change in privileges, clinical performance data and results of the practitioner's performance improvement program activities; and

11.4.4 External Sources. Pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

11.5 Special Conditions for Dental Privileges. Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a member of the medical staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral maxillofacial surgery and demonstrated current competence.

11.6 Special Conditions for APC Staff Requests for privileges from APCs are processed in the same manner as requests for clinical privileges by physician providers. Only those categories of APCs approved by the Board for providing services at the hospital are eligible to apply for privileges and APC Staff membership. APCs may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care, **unless otherwise provided by the hospital and their licensure or certification**. The privileges of APC staff shall terminate immediately, without right to due process, in the event that the employment of the APC with the hospital is terminated for any reason or if the employment contract or sponsorship of the APC with a physician member of the medical staff organization is terminated for any reason.

11.7 Special Conditions for Podiatric Privileges. Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a member of the medical staff that will be recorded in the medical record.

11.8 Special Conditions for Residents or Fellows in Training

11.8.1 Rights and Responsibilities. Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in

accordance with the written training protocols developed by the Medical Education Committee in conjunction with the residency training program.

11.8.2 Protocols. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

11.8.3 Reports. The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

11.9 Telemedicine Privileges.

11.9.1 Only Telemedicine Services. Practitioners providing only telemedicine services to the hospital from a distant site will not be appointed as members of the medical staff but must be granted privileges at this hospital if, and only if, these services include prescribing care or otherwise treating patients.

11.9.2 Interpretation and Second Opinions. Practitioners providing telemedicine services limited to interpretation and second opinions do not require privileges at this hospital.

11.9.3 Telestroke, Consultation Panels, and Patient Care Services. Practitioners providing official readings of images, tracings or specimens through a telemedicine mechanism, serving on consultation panels to the Division of Emergency Services, providing telestroke or other treatment, care or services to patients, must:

a. Privileges. Be granted clinical privileges at the hospital in accordance with this credentialing procedure manual; or

b. Contract. In lieu of being granted clinical privileges by the hospital, have a written agreement with the telemedicine distant-site provider that enables the hospital to rely on the credentialing and privileging decisions made by the telemedicine distant-site provider with respect to the telemedicine practitioners providing telemedicine services to the hospital in accordance with the hospital's telemedicine policy.

11.10 Locums Privileges.

11.10.1 Scope and Privileges. This category is restricted to physicians and APCs employed by Presbyterian Healthcare Services that have Active or Associate Medical Staff membership or clinical privileges in good standing at other hospitals within the Presbyterian Healthcare Services who are granted locums privileges at this hospital. The term "locums" as used in these bylaws and Credentials Procedures Manual is not intended to identify the status of a practitioner for Medicare or other billing purposes.

11.10.2 Rights and Responsibilities. Locums privileges enable the hospital to fulfill unmet patient care needs for treatment and services consistent with the terms of a practitioner's employment agreement.

11.10.3 Compliance. Individuals with locums privileges must comply with applicable medical

staff and hospital policies and procedures and participate in the organizational and administrative affairs of this hospital's medical staff to the extent that they apply to staff holding clinical privileges, including without limitation, quality/performance improvement and peer review, credentialing, risk and utilization management, and medical records completion activities.

11.10.4 No Medical Staff Membership. Locums privileges will be granted as privileges only with no membership on the medical staff. Individuals with locums privileges may not serve or hold office on medical staff committees and shall not be entitled to vote on medical staff issues.

11.11 Temporary Privileges

11.11.1 Authority. The hospital administrator, or designee, acting on behalf of the Board and based on the recommendation of at least one other Credentialing Authority may grant temporary privileges to an practitioner after the Central Verification Office verifies the information in the practitioner's application and the Credentialing Authority determines clinical competence.

11.11.2 Limited Circumstances. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a verified and complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

a. **Important Patient Care, Treatment or Service Need**: Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days, while the full credentials information is verified and approved.

b. **Application Awaiting Approval**: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for medical staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board.

11.11.3 Criteria. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the appropriate Credentialing Authority:

a. Current licensure;

b. Education training and experience;

c. Current competence;

d. Current DEA and New Mexico controlled substance registration (if applicable);

e. Current professional liability insurance in the amount required;

f. Malpractice history;

g. One positive reference specific to the applicant's competence and ability to perform the privileges requested from an appropriate medical peer;

h. Satisfactory query to the OIG's list of Excluded Individuals/Entities and the National Practitioner Data Bank; and

i. Eligibility for Track 1 or Track 3 consideration.

11.11.4 Other Requirements. Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges.

11.11.5 Compliance. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the medical staff and hospital in all matters relating to their temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

11.11.6 Termination of temporary privileges: The hospital administrator acting on behalf of the Board and after consultation with at least one other Credentialing Authority, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the medical staff bylaws may impose the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the hospital administrator or their designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

11.11.7 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded elsewhere in these bylaws if their request for temporary privileges is refused or if all or any part of their temporary privileges are terminated or suspended unless the decision is based on clinical competence or unprofessional conduct.

11.12 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of clinical service affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

11.12.1 Termination. Emergency privileges terminate when the emergency ceases.

11.12.2 Emergency Definition for Privileging Purposes. For the purposes of emergency privileges, "emergency" means a condition where any delay in administering patient care would result in serious permanent patient harm or would jeopardize the patient's life.

11.13 Disaster Privileges:

11.13.1 Basis. If the hospital's Disaster Plan has been activated pursuant to any officially declared emergency by local, state, or national authorities and the organization is unable to meet immediate patient needs, the hospital administrator, any Credentialing Authority individual, and other individuals identified in the hospital's Disaster Plan with similar authority, may, on a case-by -case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected practitioners.

11.13.2 Knowledge. The individual granting disaster privileges must have knowledge of the practitioner's ability to practice their specialty within the standard of care, whether through personal knowledge, presentation by a current medical staff member with personal knowledge, or through documentation of licensure and expertise provided below.

11.13.3 Eligibility. To be eligible for granting of disaster privileges, a practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

a. A current picture hospital ID card that clearly identifies professional designation;

b. A current license to practice;

c. Primary source verification of the license;

d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups; or

e. 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).

11.13.4 No Guarantees. Regardless of information presented, no person is guaranteed the granting of disaster privileges.

11.13.5 Oversight. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The Credentialing Authority makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

11.13.6 Verification. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the hospital.

11.13.7 Termination of Disaster and Privileges. Once the immediate situation has passed and such determination has been made consistent with the hospital's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

11.13.8 Termination of Disaster Privileges. Any individual identified in this Section or in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges for any reason at any time. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

11.14 Preceptorship. If specifically required by a Credentialing Authority, a practitioner requesting clinical privileges who has not provided acute inpatient care within the past twelve months must arrange for a preceptorship either with a current member in good standing of the medical staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the hospital.

11.14.1 Financial Responsibility. The practitioner must assume responsibility for any financial costs required to fulfill the preceptorship requirements.

11.14.2 Preceptorship Scope and Activities. A description of the preceptorship program, including the scope and intensity of required preceptorship activities and the details of monitoring and consultation must be written and submitted for approval to the appropriate Credentialing Authorities.

11.14.3 Written Report. Prior to the termination of the preceptorship period, the preceptor must submit a written report assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

11.15 FPPE – Training. A practitioner in good standing with Active or Associate Medical Staff membership or clinical privileges at the hospital or another PHS hospital may be granted FPPE – Training privileges to facilitate the requisite training necessary for a practitioner to expand their delineation of hospital privileges. The practitioner requesting the expanded privilege(s) and the practitioner providing the training may apply for FPPE – Training privileges, as appropriate, depending on the location of the PHS hospital where the training occurs.

11.15.1 Limited in Scope. FPPE – Training privileges will be limited to the procedure(s) sought to be added to a practitioner's current delineation of privileges and will remain in place until the practitioner demonstrates clinical competence in the requested new privilege.

11.15.2 Classification. If FPPE-Training privileges are the sole privilege held by a practitioner at the hospital, FPPE- Training privileges will not give the practitioner the right to serve or hold office on the medical staff or vote on medical staff issues but will be assigned a "privileges only" classification. However, if a practitioner requests FPPE – Training privileges as an additional privilege at hospital where that practitioner is already on staff, FPPE – Training privileges will not affect the Medical Staff status (such as active, associate, privileges only, etc.) of that practitioner.

11.15.3 Training Activities. As part of the FPPE – Training privilege application, a description of the scope of training, including details of observation, monitoring, consultation, and evaluation, must be written and submitted for approval to the appropriate Credentialing Authorities.

11.15.4 Written Report. Subject to other provisions in the bylaws and Appendix B, the Credentials Manual, FPPE – Training privileges will remain in effect until the practitioner who provided the training submits a written report to the designated Credentialing Authority assessing, at a minimum, the practitioner's demonstrated clinical competence related to the privileges requested.

12 Reapplication, Resignation, Leaves of Absence and Appeals

12.1 Reapplication After Adverse Credentials Decision. Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the medical staff or for clinical privileges for a period of three (3) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

12.2 Request for Modification of Appointment Status or Privileges. A staff appointee in connection with reappointment may request modification of staff category, clinical service assignment, or clinical privileges by submitting a written request to the medical staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment. A practitioner who wishes to no longer exercise, or wishes to restrict or limit the

exercise of, particular privileges that have been granted shall send written notice, through the medical staff office, to the credentials committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

12.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign their staff appointment and/or clinical privileges must provide written notice to the appropriate division chief or president of the medical staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which they are responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

12.4 Exhaustion of administrative remedies. Every practitioner agrees that they will exhaust all the administrative remedies afforded in the various sections of the credentialing procedures manual and the bylaws before initiating legal action against the hospital or its agents.

12.5 Reporting requirements. The hospital administrator or their designee shall be responsible for assuring that the hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes, the New Mexico Review Organization Immunity Act and its successor statutes, and other applicable federal and state obligations to report any professional review action against a physician or other licensee on the medical staff or the acceptance or surrender of clinical privileges by such individual while under investigation, or in lieu of investigation.

12.6 Leave of Absence

12.6.1 When Required. A leave of absence must be requested for any absence from the medical staff and/or patient care responsibilities longer than 90 days, including absences related to the individual's physical or mental health or to the ability to care for patients safely and competently.

12.6.2 Written Request and Approval. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the president of the medical staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

12.6.3 Conduct During Leave. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill medical staff responsibilities.

12.6.4 Termination of Leave. At least fourteen calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Medical Staff Office . The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from their physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. In these circumstances the MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures

concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or their appointment and/or clinical privileges shall lapse at the end of the appointment period.

12.6.5 Failure to Request Reinstatement. Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in these bylaws. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

13 Practitioners Providing Contracted Services and Medical Administrative Officers

13.1 Contracted Services. When the hospital contracts for care services with practitioners, including but not limited to those who provide readings of images, tracings or specimens through a telemedicine mechanism, such practitioners providing contracted services will be permitted to do so only after being granted privileges at the hospital. This also applies to individuals providing contracted services onsite.

13.1.1 Qualifications. A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of their appointment category as any other applicant or staff appointee.

13.1.2 Disciplinary Action. The terms of the medical staff bylaws will govern disciplinary action taken by or recommended by a Credentialing Authority.

13.1.3 Effect of Contract or Employment Expiration or Termination. The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

13.2 Medical Administrative Officers. A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

13.2.1 Appointment and Privileges. Each medical administrative officer must achieve and maintain medical staff appointment and clinical privileges appropriate to their clinical responsibilities.

13.2.2 Effect of Removal from Office or Adverse Change in Appointment or Privileges:

a. Contract Controls. Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on their remaining in office.

b. No Contract. In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges.

c. **Appointment or Privileges Change**. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.

13.2.3 **Procedural Rights**. A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract, a consequence of removal from office.