

**BAYLOR ALL SAINTS MEDICAL CENTER
FORT WORTH, TEXAS**

ALLIED HEALTH CREDENTIALING PROCEDURES MANUAL

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DEFINITIONS

The following definitions apply to the provisions of these Policies Governing Allied Health Professionals. The definitions are presented in alphabetical order.

1. **Allied Health Professional** or **AHP** means an individual who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline which the Board of Directors has determined to allow to practice in the Hospital. An "independent AHP" is licensed by the state and permitted by the Hospital to provide services in the Hospital without the direction or immediate supervision of a Medical Staff Member. A "Dependent AHP" functions in a medical support role to and under the direction and supervision of a Medical Staff Member. Allied health professionals are not members of the Medical Staff.
2. **Board of Directors** or **Board** means the governing body of the Hospital, the Board of Directors of Baylor All Saints Medical Center. As appropriate to the context and consistent with the Bylaws of the Hospital and delegations of authority made by the Board, it may also mean any committee of the Board or any individual authorized by the Board to act on its behalf on certain matters.
3. **Chief of Staff** means that member of the Active Staff elected pursuant to the Bylaws to be the principal elected officer of the Staff. The Chief of Staff may designate a representative to perform his responsibilities per the Chain of Command Policy in the MSCS Department.
4. **Cityview Facility** means Baylor All Saints Medical Center at Cityview, the assumed name under which the Hospital operates its acute care general hospital located at 7100 Oakmont Boulevard, Fort Worth, Texas.
5. **Clinical Privileges** or **Privileges** mean the permission granted pursuant to the Bylaws and related manuals to a practitioner to provide specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
6. **Credentials Committee or CC** means the Credentials Committee of the Medical Staff.
7. **Dentist** means an individual with a D.D.S. or D.M.D. degree, or its equivalent, who is licensed to practice dentistry and whose practice is in the area of general dentistry or a specialty thereof.
8. **Ex Officio** means service as a member of a body by virtue of office or position held. Unless otherwise expressly provided, an ex officio member of a body has no voting rights, shall not be counted in determining the existence of a quorum, and shall hold the ex officio position only for so long as he/she holds the position upon which the ex officio status is based.
9. **Facilities** means the Baylor All Saints Medical Center at Cityview and Baylor All Saints Medical Center at Fort Worth collectively.
10. **Facility** means Baylor All Saints Medical Center at Cityview or Baylor All Saints Medical Center at Fort Worth.
11. **Fort Worth Facility** means Baylor All Saints Medical Center at Fort Worth, the assumed name under which the Hospital operates its acute care general hospital located at 1400 Eighth Avenue, Fort Worth, Texas.
12. **Hospital** means any entity affiliated with Baylor All Saints Medical Centers.

13. **Hospital President** Baylor All Saints Medical Center President means the individual appointed by the Board of Directors as the President of the Hospital to be responsible for the overall executive supervision and management of the Hospital. The Hospital President may, consistent with his responsibilities under the Bylaws of the Hospital, designate a representative to perform his responsibilities under the Medical Staff Bylaws and related manuals.
14. **Medical Staff Executive Committee or MEC** means the Medical Staff Executive Committee.
15. **Medical Staff** or **Staff** is the organizational component of the Hospital that includes all practitioners who are appointed to it.
16. **Medical Staff Bylaws** or **Bylaws** means the Bylaws of the Medical Staff. The Manuals are:
 - Medical Staff Bylaws Manual
 - Medical Staff Credentialing Procedures Manual
 - Medical Staff Fair Hearing Plan
 - Medical Staff Organization Manual
 - General Rules and Regulations of the Medical Staff
 - Allied Health Credentialing Procedures Manual
17. **Medical Staff member in good standing** or **member in good standing** means a practitioner who has been appointed to the Medical Staff and who is not under either a full or partial suspension.
18. **Medical Staff Services (MSS)** means the Medical Staff Services Department.
19. **Medical Staff Year** means the 12-month period commencing on March 1 of each year and ending on the last day of February of the next year.
20. **Oral Surgeon** means an individual with a D.D.S. or equivalent degree who is licensed to practice dentistry and who has successfully completed an approved postgraduate program in oral surgery.
21. **Physician** means an individual with a M.D. or D.O. degree, who is licensed to practice medicine.
22. **Podiatrist** means an individual with a D.P.M. degree, who is licensed to practice podiatry.
23. **Practitioner** means, unless otherwise expressly provided, any physician, oral surgeon, dentist, or podiatrist who either: (a) is applying for appointment to the Medical Staff and for clinical privileges; or (b) currently holds appointment to the Medical Staff and has specific delineated clinical privileges; or (c) is applying for or is exercising clinical privileges pursuant to the applicable section of the Credentialing Procedures Manual; or (d) is applying for or is exercising temporary privileges pursuant to the applicable section of the Credentialing Procedures Manual.
24. **Prerogative** means a participatory right granted, by virtue of Staff category or otherwise, to a Staff member or allied health professional.

25. **Professional Affairs Committee** or **PAC** means the Professional Affairs Committee of the Board. This Committee serves as the communication link between the Medical Staff and the Board.
26. **Special Notice** means written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgment of receipt.
27. **Specified Services** means the permission granted pursuant to the Policies Governing Allied Health Professionals to an AHP to perform specific clinical functions or activities in the treatment of patients.

CONSTRUCTION OF TERMS AND HEADINGS

Words used in the Bylaws and related manuals will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in the Bylaws and related manuals are for convenience only and are not intended to limit or define the scope or effect of any provision herein.

PART ONE. AUTHORIZATION AND CONTROL PROVISIONS

1.1 DEFINED

1.1-1 GENERALLY

An allied health professional (AHP) is an individual other than a physician, oral surgeon, dentist, or podiatrist, and who is not an employee ~~or contracted employee~~ of the Hospital, who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline which the Board of Directors has determined to allow to practice in the Hospital and who either:

- a) is licensed by the state and permitted by the Hospital to provide specified services in the Hospital without the direction or immediate supervision of a physician (i.e., independent AHP or IAHP);
or
- b) functions in a medical support role to and under the direction and supervision of a physician (i.e., physician-directed AHP or PDAHP).

Allied health professionals are not members of the Medical Staff.

This credentialing manual only applies to AHP's not employed ~~or contracted~~ by the Hospital.

1.1-2 CURRENT CATEGORIES OF ALLIED HEALTH PROFESSIONALS

Current policy of the Board of Directors permits the following categories of IAHPs and PDAHPs to provide specified services in the Hospital:

- a) **Independent AHP Categories:**
Psychologist
Licensed Professional Counselors
Certified Nurse Midwives
- b) **Physician-Directed AHP Categories:**
All others

1.1-3 PROCEDURE FOR APPROVAL OF NEW TYPES OF ALLIED HEALTH PROFESSIONALS

- a) **Request:** A request to establish a new allied health professional category must be submitted in writing to the Credentials Committee (CC) through Medical Staff Services (MSS). This request must include:
 - 1) A statement outlining the need for the category.
 - 2) The statement of qualifications required under Part 1.2 below; and
 - 3) The scope of services description required under Part 1.7 below.

- b) **Review and Approval:** The MSS shall review the request, obtaining input as appropriate from the applicable Department Chief, Section Chief and/or Hospital Department Head, and shall transmit its recommendation on the category, the statement of qualifications, and the position description to the CC. Once completed, the CC shall either forward the information back to the Department Chief for further review or forward the request to the MEC. The MEC shall review the recommendation and shall refer the matter back for additional input or forward its recommendation along with those of the CC to the PAC. If the recommendation of either the CC or the MEC is not unanimous, the nature of and reason for the dissenting view must be documented and transmitted with the majority's recommendation. The PAC shall review the recommendations and any dissenting views. It shall refer the matter back for additional input and subsequent recommendation or shall take action to approve or deny the request.

1.2 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Every AHP who applies for or is exercising specified services must at the time of initial application for affiliation and, if approved, continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the Medical Staff and of the Hospital the following qualifications and any additional qualifications as are set forth for his particular category of AHPs:

1.2-1 LICENSURE

Current license, registration certification or such other credential, if any, as may be required by Texas law or by the Board of Directors of the Hospital.

1.2-2 PROFESSIONAL EDUCATION AND TRAINING

- a) **Psychologist:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested. Possess an earned doctoral degree in psychology from an accredited educational institution and have completed at least two years in an organized healthcare setting supervised by a licensed psychologist, one of which must have been post-doctoral and preferably an internship endorsed by the American Psychological Association or the Association of Professional Internship Centers.

- b) **Licensed Professional Counselor:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested, for patients of all age groups, except as specifically excluded from practice **and** one of the following: Possess an earned Master's Degree in Counseling or its substantial equivalent of at least 45 semester hours completed at an accredited school **and** supervised practicum experience that is primarily counseling in nature of at least 300 clock hours which were part of the graduate program. The practicum information must appear on the official transcript. For practicums beginning on or after June 30, 1990, at least 100 hours of direct client counseling contact must be shown. Current active licensure by the Texas State Board of Licensed Professional Counselors.
- c) **Licensed Masters Social Worker:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested, for patients of all age groups, except as specifically excluded from practice; **and** one of the following: Possess an earned doctoral degree or master's degree in Social Work from an accredited graduate program approved by the Texas Department of Human Services; **or** possess an earned doctoral degree or master's degree not in Social Work from an accredited program approved by the Texas Department of Human Services, and the successful completion of two years actual and active Social Work experience approved by the Texas Department of Human Services. Current active licensure by the Texas Department of Human Services.
- d) **Non-Physician Surgical Assistant:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested, for patients of all age groups, except as specifically excluded from practice; **and** one of the following: Current certification as a Certified Surgical Technologist by the Liaison Council on Certification for the Surgical Technologist, or graduate of an accredited school of nursing **or** current active licensure to practice in the State of Texas, with a minimum of one year of surgical assistant experience, **or** acceptable supervised on-the-job training as a surgical assistant, with a minimum of one year of surgical assistant experience. R.N.'s requesting first assistant privileges must be certified as a C.N.O.R.
- e) **Certified Physician Assistant:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested. Must have completed an AMA-accredited Physician Assistant Program. Certification by the National Council on Accreditation of Physician Assistants. Must be licensed as a Physician Assistant by the Texas State Board of Medical Examiners. The sponsoring physician must apply to the Texas State Board of Medical Examiners and be approved for supervision of the Certified Physician Assistant.
- f) **Certified Nurse Midwife:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested. Satisfactory evidence of graduation from an educational program in Nurse-Midwifery accredited by the American College of Nurse-Midwives. Current certification by, or active participation in the

examination process leading to certification, by the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council.

- g) **Physician Sponsored Nurse:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested, for patients of all age groups, except as specifically excluded from practice; **and** one of the following: Possess a Diploma Degree, Associate Degree, Bachelor of Science Degree in Nursing from an accredited educational institution, **and** current active licensure by the Texas State Board of Nurse Examiners or the Texas State Board of Vocational Nurse Examiners
- h) **Advanced Nurse Practitioner:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested, for patients of all age groups, except as specifically excluded from practice; **and** one of the following: Possess a Diploma Degree, Associate Degree, Bachelor of Science in Nursing **and** a Master's Degree in Nursing from an accredited educational institution, **and** current active licensure by the Texas State Board of Nurse Examiners or the Texas State Board of Vocational Nurse Examiners; **and** current active certification as an Advanced Nurse Practitioner, and specialized training for the privileges requested.
- i) **Certified Registered Nurse Anesthetist:** Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested, for patients of all age groups, except as specifically excluded from practice; **and** the following: Graduate of an accredited school of nursing **and** current active licensure to practice in the State of Texas, **and** graduate of an accredited school of Nurse Anesthesia **and** current active licensure as an Advanced Nurse Practitioner in the State of Texas. Current ACLS Certification; if new Affiliate Staff Member, ACLS must be obtained within one (1) year after privileges are granted.
- i) **Physician Sponsored Assistant:** Clinical and non-clinical individuals who have current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested. Allied health practitioners in this category include Medical Physicists, individuals who review medical records and conduct patient education and EEG technicians.
- j) **Perfusionist** – Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested, for patients of all age groups, except as specifically excluded from practice; **and** the following: Graduate of a Perfusion Education Program accredited by the Accreditation Committee for Perfusion Education and approved by the Commission on Accreditation of Allied Education Program or their successors **or** an education program that is at least as stringent as those established by the Accreditation Committee for Perfusion Education and approved by the Commission on Accreditation of Allied Health Education Program of the AMA or their successor. All Perfusionists must be licensed by the Texas State Board of Examiners of

Perfusionists.

- k) **Dental Assistant** - Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested, for patients of all age groups, except as specifically excluded from practice; **and** one of the following: Possess a Certified Dental Assistant credential, or have a minimum of one year experience as a Dental Assistant.

1.2-3 EXPERIENCE AND PROFESSIONAL PERFORMANCE

Current experience and results, documenting the ability to provide patient care services at an acceptable level of quality and efficiency in each Hospital setting where specified services are or will be provided.

1.2-4 COOPERATIVENESS

Ability to work with others in the Hospital environment, federal and state regulatory agencies and programs and third party insurers affecting health care delivery and the reimbursement thereof, visitors and the community in general in a cooperative, professional manner, including refraining from conduct which constitutes a pattern of disruption such as to adversely affect the quality or efficiency of patient care services in the Hospital or the Hospital's financial integrity or its ability to satisfy its mission.

1.2-5 SATISFACTION OF OBLIGATIONS

Satisfactory compliance with the obligations outlined in Part 1.5 of these Policies.

1.2-6 PROFESSIONAL ETHICS AND CONDUCT

To be of good moral character and to adhere to generally recognized standards of professional ethics.

1.2-7 HEALTH STATUS

- a) **Physical or Mental Impairment:** To be able to perform the essential functions of his category of AHP as approved for practice at the Hospital without regard to the existence of a physical or mental impairment which could interfere with the AHP's ability to satisfy all or any of the qualifications required under this Part or the ability to perform all or any of the specified services requested or granted. In the event of such a physical, mental or emotional impairment, the AHP shall promptly notify the Chief of Staff or the applicable Department Chief and the Hospital President, or designee, so that a determination can be made as to whether or not there is a reasonable accommodation that can be made for the impairment that will permit the AHP to continue his duties.
- b) **Substance/Chemical Abuse:** To be free from abuse of any type of substance or chemical that interferes with, or presents a reasonable probability of interfering with, the AHP's ability to satisfy any of the qualifications by his ability to perform all or any of the specified services required or granted.

1.2-8 COMMUNICATION SKILLS

To read and understand the English language, to communicate verbally and in writing in the English language in an intelligible manner, and to prepare any authorized medical record entries and other required documentation in a legible manner.

1.2-9 PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Board.

1.3 EFFECTS OF OTHER AFFILIATIONS

No AHP shall be automatically entitled to specified services merely because:

- a) he is authorized to practice in this or in any other state; or
- b) he is a member of any professional organization; or
- c) he is certified by any board; or
- d) he had, or presently has, specified services at another health care facility or in another practice setting; or
- e) he had, or presently has, those specified services or is employed at this Hospital; or
- f) he is or is about to become affiliated with a practitioner or another AHP who is, or with a group of practitioners or AHPs one or more of whose members is, affiliated with the Hospital through employment, contract, Medical Staff appointment or otherwise.

1.4 PREROGATIVES OF ALLIED HEALTH PROFESSIONALS

The prerogatives of an AHP are to:

- a) Perform such specified services as are defined for him, under the degree of supervision or direction of a physician member of the Medical Staff as specified in the definition of services if he is a PDAHP, and consistent with any limitations stated in the policies governing the AHP's practice in the Hospital and any other applicable Medical Staff or Hospital policies.
- b) Serve on committees, if so appointed, and with vote if so specified by the appointing authority.
- c) Attend, when invited, clinical meetings of the Staff, a Department or other clinical unit when appropriate to his discipline.
- d) Attend education meetings, when invited, of the Staff, a Department or other clinical unit, or the Hospital.
- e) Exercise such other prerogatives as the MEC with the approval of the PAC may accord AHPs in general or a specific category of AHPs.

1.5 OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS

Each AHP shall:

- a) Provide patients with care or other services at the level of quality and efficiency professionally recognized as appropriate at facilities such as the Hospital.
- b) Retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing specified services and, when necessary and as appropriate to the circumstances of the case, either arrange or alert the principal attending practitioner of the need to arrange a suitable alternative for such care and supervision.
- c) Participate in quality assessment/improvement program activities appropriate to his discipline and in discharging such other functions as may be required from time to time.
- d) When requested, attend clinical and education meetings of the Staff and of the Department and any other clinical units with which he is affiliated and any individual conference requested by any applicable Department Chief/Section Chief, medical director of a special unit, or Hospital Department Head.
- e) Abide by the Medical Staff Bylaws and related manuals, these Policies and any specific to his particular category of AHP, and all other lawful standards, policies and rules of the Medical Staff and Hospital.
- f) Prepare and complete in a timely fashion, as appropriate and authorized, those portions of patients' medical records documenting services provided and any other required records.
- g) Provide evidence to MSS, prior to expiration, of renewed license/certificate to practice in this state and professional liability insurance coverage.
- h) Within fifteen (15) days, notify the Chief of Staff and the Hospital President, or their respective designees, of: (1) Any criminal charges brought against the AHP (other than minor traffic violations not involving a DUI charge); (2) any change made or formal action initiated that could result in a change in the status of his license/certificate to practice, professional liability insurance coverage, employment by or other affiliation with a physician identified as one who supervises the AHP, affiliation with or specified services at other institutional affiliations where he provides specified services; and (3) any change in the status of current or initiation of new malpractice claims involving his professional performance.
- i) Refrain from any conduct or acts that are or could reasonably be interpreted as being beyond, or an attempt to exceed, the scope of specified services authorized within the Hospital.

Failure to satisfy any of these obligations is grounds, as warranted by the circumstances, for termination or nonrenewal of specified services or for such other disciplinary action as deemed appropriate under Part Four of these Policies.

1.6 TERMS AND CONDITIONS OF AFFILIATION

An AHP shall be individually assigned, as appropriate, to the Medical Staff Department that governs the scope of their privileges and is subject to disciplinary procedures as set forth in Part Three, Four

and Five of these policies.

An AHP's provision of specified services within any Medical Staff Department is subject to the rules and regulations of that Department and to the authority of the Chief thereof. The quality and efficiency of the care provided by the AHP's within any such Department shall be monitored and reviewed as part of the regular Medical Staff mechanism.

The specified services authorized for an PDAHP shall automatically terminate if the clinical privileges of his supervising physician are terminated or not renewed. Similarly, a PDAHP's specified services shall be automatically suspended effective upon and for the same term as a suspension of the clinical privileges of his supervising physician.

1.7 SCOPE OF SPECIFIED SERVICES

Notwithstanding the apparent scope of specified services permitted to any particular category of AHPs or any individual AHP under Texas law or licensure, limitations may be placed on the AHP's authorized scope of services in the Hospital as deemed necessary either for the efficient and effective operation of the Hospital or any of its departments or services, or for management of personnel, services and equipment, or for quality or efficient patient care, or as otherwise deemed by the PAC to be in the best interests of patient care in the Hospital.

1.7-1 INDEPENDENT AHP

An AHP who is licensed, certified or registered to provide patient care services without supervision or direction by a member of the Medical Staff.

1.7-2 PHYSICIAN-DIRECTED AHP

An AHP who may provide patient care services only under the supervision or direction of a member of the Medical Staff.

Written guidelines defining the scope of specified services that may be provided by each category of physician-directed AHPs shall be developed by the CC, subject to review and approval as provided in Part 1.1-3 above, and with input from the physician supervisor of the AHP, and, as appropriate, from representatives of the Medical Staff, Hospital management, the Hospital's other professional staffs, and applicable AHP categories.

Such guidelines must include at least:

- a) Qualifications applicable to all services that may be authorized and special requirements that attach to specific services.
- b) Description of the services to be provided and procedures to be performed, including any special equipment, procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the patient's medical record.
- c) Definition of the degree of assistance that may be provided to a physician in the treating of patients on Hospital premises and any limitations thereon, including the degree of physician supervision required.

1.8 RESTRICTIONS ON SERVICES WAIVED IN AN EMERGENCY

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, an AHP 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 AHP's license or certificate but regardless of scope of specified services. In such an emergency, the AHP is obligated to summon all consultative assistance deemed necessary and to relinquish care of the patient when a physician or other more qualified professional arrives.

1.9 SUPERVISING PHYSICIAN'S OBLIGATIONS

Any physician supervising a physician-directed AHP in the care of a specific patient must:

- a) Accept full legal and ethical responsibility for the AHP's performance.
- b) Accept full responsibility for the proper conduct of the AHP within the Hospital, for the AHP's observance of all bylaws, policies and rules of the Hospital and Medical Staff, and for the correction and resolution of any problems that may arise.
- c) Be physically present or immediately available to provide further guidance when the AHP performs any task or function, except in life-threatening emergencies.
- d) Maintain ultimate responsibility for directing the course of the patient's medical treatment.
- e) Assure that the AHP provides specified services in accordance with accepted medical standards and privileges granted.
- f) Provide active and continuous overview of the AHP's activities in the Hospital to ensure that directions and advice are being implemented.
- g) Abide by all bylaws, policies and rules governing the use of AHPs in the Hospital, including refraining from requesting that the AHP provide specified services beyond, or that might reasonably be construed as being beyond, the AHP's authorized scope of practice in the Hospital.
- h) Within fifteen (15) days, notify the Chief of Staff and the Hospital President in the event any of the following occur:
 - 1) The scope or nature of his professional arrangement with the AHP changes;
 - 2) His approval to supervise the AHP is revoked, limited, or otherwise altered by action of the applicable state licensing authority;
 - 3) Notification is given of investigation of the AHP or of his supervision of the AHP by the applicable state licensing authority;
 - 4) His professional liability insurance coverage is changed insofar as coverage of the acts of the AHP is concerned.
- (i) Comply with all laws and regulations and all policies specific to the particular category of AHP governing his supervision of the AHP.

1.10 ORIENTATION OF ALLIED HEALTH PROFESSIONAL

Prior to approval for a new application, the AHP will be provided with an Educational Module which must be completed prior to the application being submitted to the Chief of the Department. The Education Module contains information on Infection Control, Safety, Patient Rights, etc. Also, once formal approval is granted, the AHP will be provided with an orientation packet, which will familiarize the professional with standard procedures and protocols at the Hospital.

1.11 IDENTIFICATION

At all times while on Hospital premises, the AHP shall wear a Baylor All Saints name tag clearly identifying himself by name and the type of AHP he is. The Baylor All Saints name tag must be turned in to the Department of Public Safety upon resignation or non-reappointment.

1.12 EVALUATION OF INDIVIDUAL ALLIED HEALTH PROFESSIONAL APPLICATIONS

The procedure for evaluating an application from an AHP forth in Part Two of these Policies. Said procedures will provide, as appropriate for the particular category of AHP, for participation of representatives of the Board, Medical Staff, Hospital management, other professional staffs, and AHPs of the same category.

PART TWO. APPLICATION PROCEDURE FOR ALLIED HEALTH PROFESSIONAL

2.1 APPLICATION AND CONTENT

An application must be submitted by the AHP in writing, signed, and on the Hospital-approved form. The application must furnish complete information concerning at least the following:

- a) **Personal Information:** Full name, social security number, addresses and telephone numbers for office and residence, birth date and other assumed names.
- b) **Physician Supervision Information:** For physician-directed AHPs, name of the physician member(s) of the Medical Staff who will supervise the AHP. The AHP's scope of privileges must be within the same scope of privileges as the supervising physician. Each such physician must sign the supervising physician acknowledgment form for the AHP. The application of a physician assistant (PA) must include a copy for each physician who is to supervise the PA in the Hospital of the permit from the Texas State Board of Medical Examiners approving that physician as a supervisor of the PA.
- c) **Education:** School name and location, major, degrees awarded, and dates attended for all undergraduate and/or professional/ other graduate schools relevant to the category of AHP for which applying.
- d) **Postgraduate Training:** Institution/school name and location, title and summary description of content of program, program director, dates attended, date completed.
- e) **Continuing Education:** Documentation of continuing education.
- f) **Professional Licenses/Registration/Certifications:** Type of each; state where held; if applicable, number; whether current or not; date of certification by the professional college or board, where applicable (e.g., National Commission on Registration of Physician Assistants); copy of current license/registration/authorization to practice in Texas and of current professional college/board certificate, where applicable.
- g) **Chronology of Professional Career (all present and prior):** Hospital affiliations, other institutional affiliations, employment with solo/group/partnership practice, with name, nature and location of each, inclusive dates, and experience at each in the specified services being requested. The chronology must cover all periods from highest professional education and training to current.
- h) **Disciplinary Actions (pending and completed):** Denials, revocations, suspensions, reductions, limitations, probations, non-renewals, voluntary relinquishments of or withdrawals of application for any of the following: professional registration/license/certificate, academic appointment, hospital/other institutional affiliation, professional society membership, board certification, professional liability insurance; full details of each to be provided.
- i) **Professional Liability Insurance:** Coverage amount and period; any claims, suits, settlements or arbitration proceedings pending or concluded with appropriate details; names of present and past insurance carriers.
- j) **Health Status:** Details of any current or prior physical or mental condition or chemical

(alcohol, drug or other) dependence that affects or affected ability to provide professional services (i.e., that is related to capability to perform the specified services requested).

- k) **Any current criminal charges** (other than motor vehicle violations) and any drug or alcohol-related charges (including motor vehicle violations) pending against the applicant and any past charges including their resolution.
- l) **Any termination or exclusion** as an approved provider in the Medicare, Medicaid, Blue Cross or other third-party or governmental payor programs, any instance of individually-targeted monitoring by those programs or their reviewing agents, and any charges that are currently pending that could lead to such determinations.
- m) **Notification** of the authorization, release and immunity provisions of the Medical Staff Bylaws and their applicability to consideration of the AHP's application and his provision of specified services in the Hospital and evidence of the applicant's agreement with them.
- n) **Acknowledgment by the AHP and by the supervising physician** of physician-directed AHPs that they will abide by these Policies, the Bylaws and related manuals, rules, regulations, policies and procedures of the Medical Staff and Hospital in all matters relating to the AHP's provision of specified services in the Hospital.
- o) **Supervising physician acknowledgment** to assume and carry out the obligations required by the policies specific to the particular category of AHP involved.
- p) **References:** Names of three individuals who have personal knowledge of your current clinical ability, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters. None of the individuals should be related to you by family or professional partnership financial association.
- q) Such other information or references as may be established in specific policies governing the category of AHP for which application is being made.
- r) Documentation of proof of date and results of last PPD test.

2.2 EFFECT OF APPLICATION

The AHP must sign the application and in so doing:

- a) Attests to the correctness and completeness of all information furnished and acknowledges that any misstatement or misrepresentation in or omission from the application, whether intentional or not, constitutes grounds for denial of specified services or for automatic revocation of previously authorized services in the event they were granted prior to the discovery of the misstatement, misrepresentation, or omission;
- b) Signifies his willingness to appear for interviews in connection with the application;
- c) Agrees to abide by the terms of these Policies, the Bylaws and related manuals, rules, regulations, policies and procedure manuals of the Medical Staff and those of the Hospital;
- d) Agrees to maintain ethical behavior and to refrain from misrepresenting his position, status or scope of authorized service to any patient, Hospital visitor, Hospital employee, Medical Staff member, or any other person affiliated with or coming in contact with the Hospital;

- e) Agrees to notify, promptly and in writing, the Chief of Staff and the Hospital President, or their respective designees, of any change in any of the information provided on the application;
- f) Authorizes and consents to Hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence;
- g) Releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the AHP's background, experience, clinical competence, professional ethics, character, health status, and other qualifications.

For purposes of this section, the term "Hospital representative" means: the Board of Directors of the Hospital and any member or committee thereof; the Hospital President or his respective designees; the Medical Staff and any member, officer, clinical unit or committee thereof; registered nurses and other employees of the Hospital; and any individual authorized by any appropriate authority of the Medical Staff or Hospital to perform specific information gathering, analysis, use or disseminating functions.

2.3 PROCESSING THE APPLICATION

2.3-1 ALLIED HEALTH PROFESSIONAL'S BURDEN AND PROOF OF IDENTITY

- a) AHP's Burden: The AHP and his supervising/employer physician, if applicable, have the burden of producing adequate information for a proper evaluation of the AHP's experience, training, current competence, ability to work cooperatively with others, and health status, and of resolving any doubts about these or any of the qualifications required for the requested specified services, and of satisfying any reasonable requests for information or clarification made by appropriate Medical Staff or Board authorities.

2.3-2 VERIFICATION OF INFORMATION

The completed application is submitted to MSS or designee. MSS, or designee, organizes and coordinates the collection and verification of the references, licensure and other qualification evidence submitted or required, and promptly notifies the applicant of any gaps in or any other problems in obtaining the information required. This must be a special notice, indicating the nature of the additional information the applicant is to provide and the time frame for response which is not to exceed thirty (30) days. Failure to respond in a satisfactory manner by that date is deemed a withdrawal of the application, unless the CC determines that the failure to respond was caused by circumstances beyond the control of the applicant. The Hospital President shall send the applicant special notice of any deemed withdrawal.

Verification shall include, without limitation:

- (a) a reasonable effort to confirm with the primary source information contained on the application;
- (b) requesting other specific information and ratings, as appropriate, from at least the past five (5) years affiliations on all aspects of the applicant's

performance at that affiliation which may bear on his qualifications for AHP appointment or the privileges requested, including ability to work with others, medical record documentation, availability for patient care; and

- (c) requesting such information from applicable sources, including governmental agencies or data banks, as is required under state or federal law.
- (d) When the pertinent collection and verification activities are accomplished, a recommendation of Type I, Type II, or Type III will be submitted by the Credentials Coordinator. The file is then forwarded to the Medical Staff Coordinator, who then notifies the Chief of each Department in which the applicant seeks privileges and requests evaluation of the application. The Chief of each Department will review the Type assigned and declare the application a Type I, Type II, or Type III according to the guidelines listed below. If all documentation requested has been received, the Chief of the Department shall determine the application to be complete and assign a Type according to the guidelines listed below:

CATEGORIES

1) TYPE I APPLICATION/REAPPOINTMENT

- a) All information complete.
- b) No adverse information received from references. References indicate physician is in good standing.
- c) No quality assurance pattern/trend identified.
- d) Approved by Chief of Department.

If the application/reappointment is deemed a Type I by the Chief of the Department a list of Type I files will be forwarded to the CC, MEC and PAC for approval. Summary profiles will be available upon request.

2) TYPE II APPLICATION/REAPPOINTMENT

- a) Adverse information received from references, and/or
- b) Pattern/trend identified in quality assurance reviews, and/or
- c) Chief of Department has reviewed adverse information/quality assurance information and either has given his/her approval or has continued reservations/concerns.

Profiles documenting adverse information or unresolved concerns will be forwarded to CC, MEC and PCA for review.

3) TYPE III APPLICATION/REAPPOINTMENT

- a) Adverse information received from references, and/or
- b) Pattern/trend identified in quality assurance reviews, and/or
- c) Reference received indicating termination, suspension,

- d) monitoring at another hospital, and/or Falsification of pre-application, application or reappointment form, or
- e) Chief unwilling to approve application.

Profiles documenting adverse information will be forwarded to CC, MEC and PAC for review.

2.3-3 CNO REVIEW OF NURSING AHPs

Upon a determination that an application is complete, the application and all supporting documentation will be forwarded to the Chief Nursing Officer (CNO), for the purpose of reviewing the application. The facility CNO may personally or through a designee conduct a personal or telephone interview with the Practitioner. The CNO shall evaluate all matters that he/she deems relevant to arriving at a recommendation regarding clinical privileges or scope of service of nursing AHPs. The CNO may contact other individuals with personal knowledge of the practitioner's qualifications. After reviewing all pertinent information (but in no event later than 30 days after receiving the completed application), the CNO shall make a written recommendation to the Credentials Committee regarding department appointment and clinical privileges and/or scope of service to be granted, if any, along with any special conditions.

2.3-4 MEDICAL STAFF DEPARTMENT EVALUATION

The Chief of each Department in which the applicant seeks privileges, or the applicable Department committee, shall review the application and its supporting documentation and forward to the CC a written report as required by Section 2.3-7. Where applicable, the Chief of each Section in which the applicant seeks privileges prepares a similar report and forwards it through the Department Chief to the CC.

The Department Chief, or his designee, may interview the applicant. If an interview is conducted, a written summary thereof shall be prepared and included with the report required by Section 2.3-7.

If a Department Chief or Section Chief requires further information, he may defer transmitting his report but generally for no more than 45 days except for good cause.

In case of a deferral, the applicable Department Chief/Section Chief shall notify, through the MSS, the applicant, the CC chairman, and the Medical Executive Committee (MEC) in writing of the deferral and the grounds. If the applicant is to provide the additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the deadline for response which is not to exceed thirty (30) days. Failure to respond in a satisfactory manner by that date is deemed a withdrawal of the application, unless the CC determines that the failure to respond was caused by circumstances beyond the applicant's control. The Hospital President shall send the applicant special notice of any deemed withdrawal.

2.3-5 CREDENTIALS COMMITTEE EVALUATION

The CC shall review the application, the supporting documentation, the reports from the Department Chiefs and Section Chiefs, and any other relevant information available to it. The CC may, at its discretion, interview the applicant or designate one or more of its members to do so.

If the CC requires further information, it may defer transmitting its report but generally for no more than 45 days except for good cause. In case of a deferral, the CC shall notify, through the MSS, the applicant in writing of the deferral and the grounds. If the applicant is to provide the additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the deadline for response which is not to exceed thirty (30) days. Failure to respond in a satisfactory manner by that date is deemed a withdrawal of the application, unless the CC determines that the failure to respond was caused by circumstances beyond the applicant's control. The Hospital President shall send the applicant special notice of any deemed withdrawal.

The CC shall prepare its written report as required by Section 2.3-7, including a summary of any interview conducted. If the CC's conclusions are contrary to those contained in the Department Chief's report, the CC and Department Chief shall meet to discuss the differences. Following these discussions, the CC or Department Chief may determine to affirm or modify its/his original report. A written summary of the discussions and conclusions from them shall be prepared as an addendum to the CC's report. The CC/Department Chief discussions provided herein and transmittal of the CC report with all supporting documentation to the MEC.

2.3-6

MEDICAL STAFF EXECUTIVE COMMITTEE EVALUATION

The MEC reviews the application, the supporting documentation, the reports from the Hospital Department Heads, the Department Chiefs/Section Chiefs, the CC and any other relevant information available to it. The MEC shall take one of the following actions on the application with the effect as described:

- a) **Deferral**: If the MEC requires further information, it may defer transmitting its report, and it must notify the AHP and, when applicable, the supervising/employing physician, through the MSS, of the deferral. If the AHP is to provide the additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him must so state and must include a request for the specific data/explanation or release/authorization required and the deadline for response. Failure to respond in a satisfactory manner by that date is deemed a withdrawal of the application, unless the MEC determines that the failure to respond was caused by circumstances beyond the AHP's control.
- b) **Favorable Recommendation**: The MEC recommendation on the AHP's application is transmitted promptly, with all supporting information, to the PAC which shall act on it as set forth in Part 2.3-7(a) below.

2.3-7

PROFESSIONAL AFFAIRS COMMITTEE ACTION

If, in its deliberations pursuant to this Part 2.3-7, the PAC determines that it requires

further information, it may defer action but generally for not more than 45 days except for good cause, and it shall notify the AHP, the supervising/employing physician when applicable, and the Chief of Staff in writing of the deferral and the grounds.

If the AHP is to provide additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him must so state and must include a request for the specific data/explanation or release/authorization required and the deadline for response. Failure to respond in a satisfactory manner by that date is deemed a withdrawal of the application, unless the PAC determines that the delay was due to circumstances beyond the AHP's control.

- a) **On Favorable Recommendation:** The PAC may adopt or reject, in whole or in part, a favorable MEC recommendation or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made back to the PAC.

The PAC's action is effective as the final decision.

- b) **After Adverse Recommendation:** The PAC's action following a waiver of appeal after an adverse MEC recommendation or following an appeal to an ad hoc review committee is the final decision in the matter.

2.3-8

CONTENT OF REPORT AND BASES FOR EVALUATIONS, RECOMMENDATIONS AND ACTIONS

Each individual and group providing a recommendation or acting on an application shall have available the full resources of the Medical Staff and Hospital as well as the authority to use outside consultants as deemed necessary. The report of each individual or group should include his/her/its conclusions as to approval or denial of, and any special limitations on, Affiliate Staff appointment, Department and, as applicable, other clinical unit assignment, prerogatives of Affiliate Staff appointment, and clinical privileges and, if applicable, a recommendation/request that the applicant be requested to obtain a physical and/or psychiatric evaluation as provided in section 2.3-1 of this Manual. If any such conclusions are not included, the reason therefore must be stated.

All documentation and information received by any individual or group during or as part of the evaluation process must be included with the application as part of the individual's central credentials file and, as appropriate or requested, transmitted with reports. The reasons for each conclusion, recommendation or action to deny, restrict or otherwise limit and for any recommendation/request that the applicant obtain a physical and/or psychiatric evaluation must be stated. Any dissenting views from the majority position at any point in the process must also be stated, including the reason for the differing view and the information on which it is based and the alternative conclusion, if any. Any dissenting views must be transmitted with the majority report.

2.3-9

NOTICE OF DECISION

The Hospital President shall promptly give notice of the final decision to the AHP, to the supervising/employing physician when applicable.

2.3.10 TIME PERIODS FOR PROCESSING

All individuals and groups required to review or act on an application for Staff appointment and/or clinical privileges should do so in a timely and good faith manner and, except for obtaining required additional information or for other good cause, each application should be processed within the following time periods:

| <u>Individual/Group</u> | <u>Time</u> |
|-------------------------|--|
| (a) MSS/QMS | 90 days for verification of application once application is complete |

| Approval Process: 90 Days | | |
|----------------------------------|--------------------|--|
| (b) | Department Chief | After receiving notice file is ready for review. |
| (c) | CC | After receiving reports from (b). |
| (d) | MEC | After receiving reports from (c) |
| (e) | PAC | After receiving reports from (d) |
| (f) | Board of Directors | After receiving reports from (e) |

These time periods are to be deemed guidelines and are not directives such as to create any rights for an AHP to have an application processed within these precise periods. If action does not occur at a particular step in the process and the delay is without good cause, the next higher authority **will** immediately proceed to consider the application and all the supporting information or may be directed by the Chief of Staff on behalf of the MEC or by the Hospital President on behalf of the PAC to so proceed.

2.3-11 CONFLICT RESOLUTION

Whenever the PAC or Board determines that it will decide a credentials matter contrary to the recommendation of the MEC, the matter shall be submitted to a joint advisory council, composed of an equal number of representatives each from the Medical Staff and the Board appointed respectively by the Chief of Staff and the Chairman of the Board, for review and report before the final decision is made by the PAC or Board, as applicable. This joint advisory council shall convene to review the matter and submit its report to the PAC or Board, as applicable, within 60 days after a matter is referred to it.

2.3-12 TERM OF APPOINTMENT

Appointments to the Affiliate Staff and granting of clinical privileges are for a period of two (2) years and take effect on the last day of the month. The exceptions to this two-year period are as follows:

- (a) in order to achieve a system of staggered reappraisal, the appointment of some AHP members may be less than two full years; and

- (b) granting of increased privileges to an AHP may be subject to a provisional period and to review at the end of that period as well as being subject to review at the time of the AHP's review for reappointment; and
- (c) the PAC, after considering the recommendations of the applicable Departments and Sections, the CC, and the MEC, may set a more frequent reappraisal period for the exercise of particular privileges in general, for an Affiliate Staff member who has an identified health disability, for an Affiliate Staff Member who has reached an advanced age, or for an Affiliate Staff member who has been the subject of disciplinary action; and
- (d) disciplinary action involving appointment and/or clinical privileges may be initiated and taken in the interim between reappraisals under the appropriate provisions of this Manual; and

2.3-13 TEMPORARY PRIVILEGES

Temporary privileges may be granted only in the circumstances and under the conditions described in the sections listed below and only when the information available supports a Type I recommendation (regarding the requesting AHP's qualifications, ability and judgment to exercise the privileges requested). Under all circumstances, the AHP requesting temporary privileges shall agree to abide by the Medical Staff Bylaws and related manuals, rules, and policies of the Staff in all matters relating to his activities at the Hospital.

The Hospital President, or designee, may grant temporary privileges in the following circumstances:

- (a) **Temporary Privileges:** To an applicant for initial appointment, but only after: receipt of an application for Affiliate Staff appointment, including a request for specific privileges; completion of the application verification process as defined in section 2.3-2 of this Manual, including receipt of all possible responses; and a fully affirmative Type I recommendation by each applicable Department Chief, Chairman of the CC, and the President/CEO. Temporary Privileges may be granted in the following instances only:
 - A. To fulfill an urgent patient care need

Temporary privileges may be granted in these circumstances for a period of ninety (90) days.

- (b) **Care of Specific Patient:** Care of Specific Patient privileges may be granted to an AHP to assist in the care of a specific patient at the request of a member of the Medical Staff, but only after receipt of a completed application, which includes a request for the specific privileges desired; written concurrence of the applicable Department Chief, Section Chief, Chief of Staff and the Hospital President; at least telephonic verification of appropriate licensure and professional liability insurance coverage; a fully positive reference specific to the privileges being requested from a responsible medical staff authority at the AHP's current principal hospital, preferably whose professional skills and competence are known directly or by reputation to the Chief of Staff, or to some other Medical Staff authority.

Temporary privileges of this nature may not be granted in more than one (1) instance in any 12-month period after which the AHP must apply for Staff appointment.

(c) **Termination**

The Hospital President, with recommendation of the Department Chief and the Chief of Staff may terminate any or all of a AHP's temporary privileges. Temporary privileges granted under this section shall automatically terminate in the event of an adverse recommendation or action by the MEC, the PAC or the Board. The Hospital President shall send the practitioner special notice of any deemed termination.

An AHP is not entitled to the rights afforded by the Grievance Procedure because his request for temporary privileges is refused, terminated or suspended.

PART THREE. PROCEDURES FOR REAPPOINTMENT AND REAPPRAISAL OF PRIVILEGES

3.1 INITIAL REVIEW PERIOD FOR ALLIED HEALTH PROFESSIONALS

3.1-1 APPLICABILITY, DURATION AND CONDITIONS

For purposes of these Policies, each AHP newly approved for specified services shall be subject to a formal initial review 24 months after having been formally approved to provide services in the Hospital. An AHP's provision of specified services during any review period is subject to any conditions or limitations imposed as part of the grant of services, or as may be imposed during the term of the review period as a result of disciplinary action taken pursuant to Part Four of these Policies.

Re-evaluation of each AHP will be accomplished on a biannual basis beginning with the successful conclusion of the probationary period or concurrent with the reappraisal of the Medical Staff member who employs or has a formal affiliation with the AHP.

3.2 INFORMATION COLLECTION AND VERIFICATION

3.2-1 Reappointment Process

On or before four (4) months prior to the date of expiration of an AHP's appointment and/or clinical privileges, the MSS, or designee, shall notify him of the date of expiration and send him an application for reappointment/reappraisal to be completed. At least four (4) months prior to the expiration date, the AHP shall furnish, in writing, on the application for reappointment: (a) complete information and all documents necessary to bring his file current on the items listed in section 1.2 of this Manual; (b) continuing training and education external to the Hospital during the preceding period; (c) specific request for the clinical privileges requested for the upcoming term, including any basis for changes from the privileges currently held; (d) requests for changes in Department or other clinical unit; (e) documentation of proof of date and results of last PPD test. The AHP must sign the reappointment application and in so doing accepts the same conditions as stated in section 1.4 in connection with the initial application.

If the AHP has not returned his completed application for reappointment/reappraisal by the first day of the fourth month prior to the expiration date, MSS shall send him special notice that his application/extension request has not been received and that he has a 14-day grace period in which to submit the application/extension request.

Failure, without good cause, to provide the fully complete reappointment/reappraisal application with all of the above information results in automatic termination of appointment and/or privileges at the expiration of the current term.

MSS verifies the information provided on the reappointment/reappraisal application generally in the same manner as provided in section 2.3 for the initial application process. The MSS notifies the AHP of any information inadequacies or verification problems by special notice, indicating the nature of the additional information the AHP is to provide and the time frame for response which is not to exceed

thirty (30) days. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a withdrawal of the application, unless the CC determines that the failure to respond was caused by circumstances beyond the AHP's control. The Hospital President shall send the applicant special notice of any deemed withdrawal.

In addition to any other requests made of a AHP under this Part Two, if the evidence at the Hospital of the AHP's current clinical competence to exercise the privileges requested is not sufficient to permit the applicable Staff and Board authorities to make an informed judgment as to his competence in exercising the clinical privileges requested, the AHP shall have the burden of providing evidence of clinical performance at his other institutional affiliations in such form as may be required by said authorities.

MSS notifies the Chief of each Department and Chief of each Section in which the AHP exercised privileges during the last period of appointment and the Chief of each Department and Chief of each Section in which the AHP is requesting appointment or privileges as to when the reappointment/reappraisal application and the supporting information and the AHP's credentials file, or relevant portions thereof, with the information required by section 2.1 are available for review.

a) **From Internal Sources**

When the pertinent collection and verification activities are accomplished, the file is forwarded to the Medical Staff Coordinator. The MSS consolidates for review at the time of reappointment/reappraisal all available and relevant information regarding the individual's professional and collegial activities, performance and conduct at the Hospital. Such information, which together with the information obtained under section 2.1 above shall form the basis for recommendations and action, shall include, without limitation:

- 1) patterns of care and utilization as demonstrated in the findings of quality/risk/utilization assessment, review and improvement activities;
- 2) participation in relevant continuing education activities;
- 3) sanctions imposed or pending and other problems;
- 4) health status;
- 5) if applicable, timely and accurate completion and preparation of medical records;
- 6) cooperativeness in working with other AHP's, practitioners and Hospital personnel;
- 7) compliance with all applicable bylaws, policies, rules, and procedures of the Hospital and Medical Staff;
- 8) any other pertinent information that may be relevant to the AHP's privileges at the Hospital, including the AHP's activities at other hospitals and his practice outside the Hospital.

3.3 DEPARTMENT EVALUATION

The Chief of each Department and each Chief of each Section in which the AHP's requests or has exercised privileges shall review the reappointment/reappraisal application and its supporting information, the information gathered under section 2.1 above, and other pertinent aspects of the AHP's file and evaluate the information for continuing satisfaction of the qualifications for appointment, the clinical unit(s) and category of assignment and the privileges requested. In the case of a Department Chief's reappointment, the review under this section shall be conducted by the Chief of Staff or designee.

A Department Chief or Section Chief, or their respective designees, may, at their discretion, interview a member applying for reappointment. A written summary of any such interview must be prepared and included with the report required below.

If a Chief requires further information, he shall notify, through the MSS, the AHP, in writing of the information required. The notice to him must be a special notice and must include a request for the specific information required and the deadline for response which is not to exceed thirty (30) days. Failure to respond in a satisfactory manner by the date specified is deemed a resignation of Affiliate Staff appointment and all clinical privileges, unless the CC determines that the failure to respond was caused by circumstances beyond the AHP's control. The Hospital President shall send the AHP special notice of any deemed resignation, and any such resignation shall carry the same obligations as provided in Part 4 of this Manual.

Each applicable Chief forwards to the CC a written report, including conclusions regarding reappointment or non-reappointment, Department and other clinical unit assignment, and clinical privileges, or if no such conclusions are made, the reason therefore. Included in any Chief's report must be any actions or information contained in the Department's/Section's files that was not previously transmitted for inclusion in the AHP's credentials file concerning his clinical performance, fulfillment of Affiliate Staff membership, or satisfaction of any other qualifications for appointment or the clinical privileges granted.

3.4 CREDENTIALS COMMITTEE EVALUATION

The CC shall review the reappointment/reappraisal application and its supporting information, the information gathered under section 2.1 above, other pertinent aspects of the AHP's file, the Department Chiefs' and Section Chiefs' reports and all other information available to it and evaluate it for continuing satisfaction of the qualifications for Affiliate Staff appointment, and category of assignment and the privileges requested. If the CC requires further information, it shall notify, through the MSS, the AHP's in writing of the information required. If the AHP is to provide the additional information, the notice to him must be a special notice and must include a request for the specific information required and the deadline. Failure to respond in a satisfactory manner by the date specified is deemed a resignation of Affiliate Staff appointment and all clinical privileges, unless the CC determines that the failure was caused by circumstances beyond the AHP's control. The Hospital President shall send the AHP a special notice of any deemed resignation, and any such resignation shall carry the same obligations as provided in Part Four of this Manual.

The CC shall prepare a written report, including conclusions regarding reappointment or nonreappointment, and Department or other clinical unit assignment, and clinical privileges, or if no such conclusions are made, the reason therefore. If the CC's conclusions are contrary to those of a Department Chief, the CC and Department Chief shall engage in the same type of joint discussions as

provided in section 2.3-9 of this Manual. The CC's report is transmitted with the Department Chiefs' and Section Chiefs' reports and supporting documentation, as required, to the MEC.

3.5 MEDICAL STAFF EXECUTIVE COMMITTEE EVALUATION

The MEC shall review the reappointment/reappraisal application and its supporting information, the information gathered under section 2.1 above, other pertinent aspects of the AHP's file, the Chiefs', and CC's reports and all other relevant information available to it. The MEC shall defer action on the reappointment/reappraisal or prepare a written report, including recommendations for, reappointment or non-reappointment, clinical unit(s), and clinical privileges, or if no such recommendations are made, the reason therefore.

3.6 FINAL PROCESSING

Final processing of reappointment/reappraisals follows the procedure set forth in sections 2.3 - 2.3-6. For purposes of reappointment/reappraisal, the terms "applicant" and "application" as used in said sections shall mean, respectively, "AHP" and "reappointment/reappraisal."

3.7 BASES FOR CONCLUSIONS, RECOMMENDATIONS AND ACTION

Each individual and group reviewing or acting on a reappointment/ reappraisal shall have available the full resources of the Medical Staff and Hospital as well as the authority to use outside consultants as deemed necessary. The report of each individual or group required to act on a reappointment/reappraisal shall state the reasons for each adverse conclusion or recommendation made or action taken. Any dissenting views at any point in the process must be documented including the reason for the differing view and the information on which it is based and the alternative conclusion, if any. The dissenting position must be transmitted with the majority report unless otherwise requested by the dissenter.

3.8 TIME PERIODS FOR PROCESSING

Transmittal of the notice to an AHP and his providing updated information is to be carried out in accordance with section 2.3-9 of this Manual. Thereafter and except for good cause, all persons and groups required to review or act must complete the same so that all reappointment/reappraisal reports are acted on by the PAC prior to the expiration date of Affiliate Staff appointment or clinical privileges of the AHP whose reappointment/reappraisal is being processed.

The time periods specified are to guide the acting parties in accomplishing their tasks. If reappointment/reappraisal processing has not been completed by an appointment/privileges expiration date, through no fault of the AHP, the AHP maintains his current appointment status and/or clinical privileges until the time that processing is completed, except where corrective action pursuant to Part Four of this Manual is taken with respect to all or any part thereof. If delay without good cause occurs at any step in the processing and is attributable to a Medical Staff or Board authority, the next higher authority may immediately proceed to consider the reappointment/reappraisal application and all the supporting information or may be directed by the Chief of Staff on behalf of the MEC or by the Hospital President on behalf of the Board to so proceed.

If the delay is attributable to the AHP's failure to provide information required by section 2.1, his Affiliate Staff appointment and/or clinical privileges terminates on the expiration date as provided in section 3.2-1 unless explicitly extended as provided therein. An appointment or privileges extension is not to be deemed to create a right of automatic reappointment or renewed privileges for the coming term.

PART FOUR. DISCIPLINARY ACTION PROCEDURES FOR ALLIED HEALTH PROFESSIONALS

4.1 CRITERIA FOR INITIATING

Criteria for initiating routine, summary or automatic suspension of an AHP's specified services are the same as provided in the Medical Staff Credentialing Procedures Manual for instituting such action against a Medical Staff member or an AHP with clinical privileges. Authorized initiating parties are also the same, plus the Head of any applicable Hospital Department. In addition, an AHP's violation of any provision of these Policies or of any Staff or Hospital rule, policy or procedure relating to his particular category of AHP may be grounds for automatic and permanent revocation of the AHP's affiliation or specified services. If an AHP's employment by or affiliation with the supervising member of the Medical Staff is terminated, said Medical Staff member shall notify the MSCS of the same immediately upon acquiring knowledge of the termination, including the reason, and the AHP's specified services shall be automatically terminated.

4.2 DISCIPLINARY ACTION

When disciplinary action is proposed or has been taken against an AHP, the Hospital President promptly notifies him and his supervising/employing physician when applicable, by special notice. If further processing is required, the matter shall be referred to the applicable Department Chief or Section Chief or to the CC and further processing shall follow the procedures set forth in Parts 2.3-4 through 2.3-7 of these Policies as applicable.

4.3 GRIEVANCE PROCEDURE

Any AHP whose membership and privileges are revoked or not renewed may request a personal meeting with the Credentials Committee. A written request must be delivered to the Chairman of the Credentials Committee, in care of Medical Staff Services, within ten (10) days after receipt of the notification of the action. The Credentials Committee will meet with the allied health practitioner within thirty (30) days of a request from the allied health practitioner. The allied health practitioner shall not be entitled to be accompanied to such meeting by any individual other than the allied health practitioner's supervising Medical Staff Member.

After such meeting, the Credentials Committee may maintain, reverse or modify its position. If the action recommended is adverse, the allied health practitioner may appeal to the Medical Staff Executive Committee. A written request must be delivered to the Chairman of the Medical Staff Executive Committee, in care of MSS, within ten (10) days after receipt of the notification of the action. The Medical Staff Executive Committee will meet with the allied health practitioner within thirty (30) days of the request for an appeal. The final action will be reported to the Board of Trustees. A letter will be sent from the Hospital President to the allied health practitioner notifying him of the final decision.

PART FIVE. REAPPLICATIONS AND MODIFICATION OF SERVICES

5.1 REAPPLICATION AFTER ADVERSE CREDENTIALS DECISION

Except as otherwise determined by the CC in light of exceptional circumstances, an AHP who has received a final adverse decision regarding, or who has voluntarily resigned or withdrawn an application for specified services is not eligible to reapply for services for a period of one (1) year from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such reapplication must include the information as required under Part 2.1 of these Policies, must be processed as an initial application, and must include such additional information as the applicable authorities of the Medical Staff and the Board may reasonably require in demonstration that the basis for the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and will not be further processed. No AHP may submit or have in process at any given time more than one application for services.

5.2 REQUESTS FOR MODIFICATION OF SPECIFIED SERVICES

An AHP may, either in connection with re-evaluation or at any other time, request modification of specified services by submitting a written request to the MSS. A modification request must contain all pertinent information supportive of the request and is processed as set forth in Part 1.12 of these Policies, including such verification with primary sources external to the Hospital and compilation of such internal data as necessary to properly evaluate the request.

An AHP who determines to no longer exercise or to restrict or limit the exercise of particular specified services which he has been granted shall send written notice of the same, through the MSS, identifying the particular services involved and, as applicable, the restriction or limitation to the applicable Department Chiefs, the applicable Section Chiefs, the applicable Hospital Department Heads, and the CC. A copy of this notice shall be forwarded to the CC for inclusion in the AHP's credentials file.

PART SIX. AMENDMENT

This Affiliate Staff Credentialing Procedures Manual shall be reviewed at least annually by the CC, and may be reviewed more frequently when deemed necessary by the appropriate Medical Staff or Board authorities. Suggestions for changes in the this Manual shall be referred to the CC which shall present its recommendations in timely fashion to the MEC.

This Manual may be amended or repealed, in whole or in part, or a new one proposed by the affirmative vote of a majority of the MEC present at a regular or special meeting at which a quorum is present. Amendments or a new Manual shall become effective upon the affirmative vote of the PAC. Any changes in the MEC's recommendations proposed by the PAC shall be first submitted to the MEC for its recommendations, including 30 working days for response, and any response timely made shall be carefully considered by the PAC prior to its action on the proposed amendments or new Manual.

PART SEVEN. ADOPTION

7.1 MEDICAL STAFF

These Policies Governing Allied Health Professionals were adopted and recommended to the Professional Affairs Committee by the Medical Staff Executive Committee on October 6, 2004

Chief of Staff
Baylor All Saints Medical Center

7.2 PROFESSIONAL AFFAIRS COMMITTEE

These Policies Governing Allied Health Professionals were approved, on behalf of the Board of Directors, by the Professional Affairs Committee on October 13, 2004, after considering the Medical Executive Committee's recommendations.

Chairman, Professional Affairs Committee
Baylor All Saints Medical Center