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WHEREAS, Yampa Valley Medical Center, a nonprofit corporation organized under the laws of the State of Colorado, hereinafter referred to as the "Hospital", is located in Steamboat Springs, Colorado; and

WHEREAS, the Hospital's purpose is to serve as a general, acute care hospital and a skilled nursing facility, and provide related services.

WHEREAS, it is recognized that the Medical Staff of Yampa Valley Medical Center is responsible and accountable to the Governing Body for the provision and oversight of care, treatment and services, performance improvement activities and uniform quality of medical care provided at the Hospital and must accept and discharge these responsibilities subject to the ultimate authority of the Hospital Governing Body. The cooperative efforts of the Medical Staff, the Chief Executive Officer, and the Governing Body are necessary to fulfill the Hospital’s obligations to its patients.

NOW, THEREFORE, in order to further the purposes set forth above, the Hospital's Governing Body hereby authorizes the provision of services by certain allied/complementary health professionals in accordance with the appropriate level of supervision by Practitioners with Privileges at the Hospital.

I. DEFINITIONS


2. The term “Allied Health Practitioners,” also referred to as “AHPs,” means those persons who are not Practitioners, but are permitted by law and by Hospital Policy to provide care, treatment and services under the supervision of a Practitioner, consistent with the Privileges or scope of practice granted to the individual AHP.
AHPs are not eligible for Medical Staff membership and are not entitled to the same hearing and appellate review rights as Medical Staff members.

3. The term “Allied Health Staff” means all AHPs who have been granted Privileges or scope of practice by the Governing Body in accordance with this AHP Manual.

4. The term “Bylaws” means the Medical Staff Bylaws, unless specific reference is made to the Bylaws of the Hospital.

5. The term “Chief Executive Officer” means the individual designated by the Governing Body to act on its behalf in overseeing the operation of Hospital or his/her/their designee.

6. The term “Compliance Program” means the Hospital’s compliance program and associate policies, as adopted and amended by the Governing Body.

8. The term “Governing Body” means the Board of Trustees of the Hospital.

9. The term “Hospital” means the Yampa Valley Medical Center, including the Doak Walker Care Center, a Colorado nonprofit corporation, also referred to as “YVMC”.

10. The term “JCAHO” means the Joint Commission on Accreditation of Health Care Organizations.

11. The term “Medical Executive Committee”, also referred to as “MEC”, means the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Body.

12. The term “Medical Staff” means all Physicians, Dentists, and podiatrists holding appropriate licenses in the State of Colorado who have been appointed as members by the Governing Body in accordance with these Bylaws and associated Policies.

13. The term “Physician” means a medical or osteopathic physician who is appropriately licensed in the State of Colorado.

14. The term “Policies” shall mean the policies, procedures, manuals of the Medical Staff, as well as criteria for specific Privileges or scope of practice for AHPs, as adopted and amended from time to time. The Policies include this AHP Manual.

15. The term “Practitioner” means a Physician, Dentist or podiatrist, who is appropriately licensed in the State of Colorado.

16. The term “Privileges” shall mean the permission granted by the Governing Body to Practitioners and certain AHPs (e.g., physician assistants and advanced nurse practitioners) to render specific patient care services.
17. Additional terms are defined throughout the Bylaws, Policies, the Quality Management Plan, and this AHP Manual.

II. THE ALLIED HEALTH STAFF

A. **AHP Categories.** The Allied Health Staff shall consist of AHPs who are commonly part of the health care team, who are licensed, registered or certified by their respective licensing, registering or certifying agencies in the State of Colorado, as applicable, and whose services are or may be of benefit to the Medical Staff of the Hospital in the delivery of quality care to their patients, and whose professional category has been approved by the Governing Body for membership on the Allied Health Staff. Approved AHP categories are set forth in Appendix A, attached hereto, as amended from time to time.

B. **Allied Health Committee.** An Allied Health Committee is established by the Governing Body, and consists of five (5) voting members: The Medical Directors of Professional Services and Quality Management, one member of the Hospital senior management, one member of the Governing Body, and the Chief of Staff. The sole function of this committee is to assess the professional categories of AHPs that will be recommended to the Governing Body for membership on the Allied Health Staff. The Governing Body will have final determination of categories of the Allied Health Staff. The senior management member of the committee will be appointed by the Chief Executive Officer. The Chair of the Governing Body will appoint the Governing Body member.

C. **Privileges and Scope of Practice.** The Credentials Committee shall recommend to the Governing Body the particular qualifications, level of Practitioner supervision, duties and responsibilities for members of each approved category of the Allied Health Staff; provided that such recommendations are not arbitrary or discriminatory and are in conformance with applicable laws. The qualifications, duties and responsibilities are described in the privilege or scope forms, subject to final approval by the Governing Body. The level of supervision, status and duties of each category of the Allied Health Staff are in Appendix A attached hereto, or in the Privilege Request Forms. Allied Health Staff members shall provide those patient care services for which they are trained, licensed or certified and privileged to perform, as described in their privilege or scope forms.

D. **QUALIFICATIONS FOR ALLIED HEALTH STAFF MEMBERSHIP**

   (1) **Objective Qualifications.** To be eligible to apply for and maintain Allied Health Staff membership, an individual must meet each of the following objective qualifications:

   (a) Be a member of an AHP category approved by the Governing Body and reflected in Appendix A, attached hereto.
(b) Be currently licensed, certified, or registered in the appropriate AHP category, as required in the State of Colorado.

(c) Possess a current, valid drug enforcement administration (DEA) number, if applicable to the Privileges or scope of practice requested.

(d) Have current professional liability insurance coverage of a type and in an amount established by the Governing Body from time to time.

(e) Have a record that is free from current Medicare/Medicaid/TriCare sanctions or felony convictions within the last three years.

(f) As required in Attachment A, sponsorship by a Practitioner who is a member of the Active Medical Staff.

(g) If seeking Privileges or scope of practice subject to an exclusive services agreement, be employed by or under contract with the Physician or Physician Group holding such contract.

(h) Comply with any additional objective qualification applicable to his/her AHP category as reflected in the privilege request form.

(2) **Category.** If an individual wishes to apply for Allied Health Staff membership and his/her category of AHP has not been approved by the Governing Body for membership on the Allied Health Staff, no action shall be taken on the application. The applicant will be advised that he/she must first request the category be added to the list of approved Allied Health Staff categories. If the category has been approved, it will be added to the list and the application shall be considered for appointment if it satisfies all other requirements. If the Governing Body does not approve the AHP category, this determination is final and is not cause for due process rights under Article II, Section F below.

(3) **Exceptions.** Exceptions to Section D(1) above may be made by the Governing Body after, either a recommendation from, or a joint conference with the Medical Executive Committee, based on important patient care needs; provided, however, that if the Governing Body determines not to grant an exception, the individual’s application will not be processed and this determination is not cause for due process rights under Article II, Section F below.

(4) **Automatic Suspension and Termination.** The Allied Health Staff membership and Privileges or scope of practice of any AHP who fails to maintain the objective qualifications under Section D(1) above or any objective qualifications for his/her AHP category as reflected in Appendix A, attached here to or in the privileges form shall be automatically
suspended for up to three months and thereafter, if the AHP fails to fully comply with the requirement, the AHP’s Allied Health Staff membership and Privileges or scope of practice shall automatically terminate. Automatic suspension and termination are not cause for due process rights under Article II, Section F below.

E. Application Process. Allied Health Professionals shall file an application for membership to Medical Staff Services, on a form approved by the Hospital. The applications for appointment and reappointment for Allied Health Staff membership shall be processed in accordance with Article III of this AHP Manual.

F. Due Process Limitations. Allied Health Staff members shall practice at the Hospital solely at the discretion of the Governing Body, after considering recommendations of the Medical Executive Committee. Practice at the Hospital is not a right, but rather only a privilege granted in the sole discretion of the Governing Body, and such privilege may be revoked at any time that the Governing Body determines that the Allied Health Staff member's services are no longer appropriate for patient care in the Hospital. Allied Health Staff applicants and members are not covered by the Hearing and Appeals Plan.

AHPs who practice under a scope of practice shall have only the right to appear before the Credentials Committee to discuss the following matters if recommended by the MEC or taken against him/her by the Governing Body without a similar recommendation by the Medical Executive Committee:

(1) Denial of initial Allied Health Staff membership, or scope of practice when objective qualifications are met; (2) denial of reappointment or renewal of scope of practice when objective qualifications are met; (3) suspension of scope of practice lasting more than 30 days, unless specifically exempted in this AHP Manual; (4) reduction, restriction or revocation of Allied Health Staff membership when objective qualifications are met.

An AHP has thirty (30) days after receiving Notice of such action to request an appearance. The request must be delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested. An AHP who fails to request an appearance within the time and in the manner specified herein waives his/her right to any appearance, and the Governing Body’s action shall be final. No AHP shall be entitled to more than one appearance for any matter. An appearance is not a “hearing” and an AHP granted a scope of practice is not entitled to have an attorney during such appearance.

An AHP who is granted Privileges shall be entitled to an abbreviated hearing and appellate review for the following matters if recommended by the MEC or taken against him/her by the Governing Body without a similar recommendation by the Medical Executive Committee:
(1) Denial of initial Allied Health Staff membership, or Privileges when objective qualifications are met; (2) denial of reappointment or renewal of scope of practice when objective qualifications are met; (3) suspension of Privileges lasting more than 30 days, unless specifically exempted in this AHP Manual; (4) reduction, restriction or revocation of Allied Health Staff membership when objective qualifications are met.

An AHP with Privileges has thirty (30) days after receiving Notice of such action to request a hearing. The request must be delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested. An AHP who fails to request an appearance within the time and in the manner specified herein waives his/her right to any hearing or appeal, and the Governing Body’s action shall be final. No AHP shall be entitled to more than one hearing and appeal for any matter.

The abbreviated hearing and appellate review shall be informal and shall not be conducted in strict accordance with the Hearing and Appellate Review Policy, but the Policy may be used for guidance on the process. Specifically, the grounds for hearing are limited to those set forth above; the AHP is entitled to Notice only in accordance with this AHP Manual; the Hearing Committee shall include at least one peer of the AHP; the AHP shall not have the right to representation by any individual (including an attorney) at the hearing and appeal; and the appellate review and final determinations may be made by one or more members of the Governing Body or the Chief Executive Officer as the Governing Body’s designee.

The Governing Body will make the final determination of all Allied Health staff categories, objective qualifications for Privileges or scope of practice, and the specific Privileges or scope of practice available for Allied Health Staff categories, upon receipt of the recommendation of the Allied Health Committee or Medical Executive Committee, as applicable, and all such determinations shall be final. The Governing Body’s denial of an AHP category, determination of qualifications and the Privileges or scope of practice for an Allied Health Staff category are not appealable events, and the affected individuals have no rights under this Section F.

G. **Not Medical Staff Members.** Allied Health Professionals are not entitled to become members of the Medical Staff and therefore are not eligible to vote, hold office, or serve on Medical Staff committees as voting members.

H. **Limits on Number of Practitioners and Categories.** The Governing Body, in its sole discretion, may at any time limit the number of individuals allowed to practice within any given Allied Health Staff category or eliminate authorization of any given Allied Health Staff category or activity within the Hospital. These determinations are not appealable events, and the affected individuals have no due process rights under Article II, Section F above.

I. **Definitions of Levels of AHP Supervision:** All members of the Allied Health Staff will be considered dependent practitioners and not licensed independent
practitioners as defined by JCAHO, regardless of their licensure, registration or certification status as described by Colorado law or regulation. Each AHP category will have a defined level of supervision as recommended by the Credentials Committee and the Medical Executive Committee and approved by the Governing Body. These levels of supervision are defined below.

**DIRECT:** Practitioner must be physically present to observe the AHP.

**INDIRECT:** Practitioner must be physically present in Hospital and immediately available to the AHP.

**AVAILABLE:** Practitioner must be able to be physically present at the Hospital within 20 minutes.

**TELEPHONE AVAILABLE:** Practitioner must be available by telephone within 10 minutes.

**PROTOCOL SUPERVISION:** The AHP carries out tasks that are specifically defined in standardized protocol or procedure, which has been approved by the Governing Body after recommendation by the Credentials Committee and Medical Executive Committee. Such protocols will define when to perform a particular task and what task to perform under what circumstance.

The level of supervision for each AHP category will be set forth in Appendix A, attached hereto.

**J. Responsibilities of the Sponsoring Practitioner.** Each AHP applicant required to do so shall have a sponsoring Practitioner who is an Active Medical Staff Member and who (1) provides a peer reference upon initial appointment and reappointment, and (2) agrees to supervise the AHP in accordance with the appropriate level of supervision, except for periods of time when another Practitioner with appropriate Privileges is acting as the supervising Practitioner for the AHP.

**K. Responsibilities of the Supervising Practitioner.** The supervising Practitioner must have Privileges at the Hospital, and shall provide the appropriate level of supervision required under applicable Colorado or federal law and in accordance with Appendix A, attached hereto.
III. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

A. The Application. Prior to submitting the application, the applicant shall be provided with a copy of this AHP Manual, other Policies and resolutions pertaining to Allied Health Staff practice in the Hospital, and an application packet. The applicant shall obtain a sponsoring member of the Active Medical Staff. All applications for appointment to the Allied Health Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body. The application shall contain sufficient information for the Credentials Committee and Medical Executive Committee to recommend approval or disapproval for Allied Health Staff membership and specific authorized Privileges or scope of practice and duties, and for the Governing Body to make a decision about Allied Health Staff membership and authorized Privileges or scope of practice and duties.

B. Burden on Applicant. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her qualifications, experience, training, character, ethics, health status, ability to work with others, and other qualifications, and for resolving any doubts about such qualifications. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time, in which case, the time frame shall be suspended pending receipt of the information. An incomplete application will not be processed.

C. Processing the Application.

(1) Criteria for AHP Membership.

(a) The objective qualifications for Allied Health Staff membership set forth in Article II of this AHP Manual and in the appropriate privilege request form must be demonstrated by all applicants for appointment to the Allied Health Staff before an application will be processed.

(b) It is the policy of the Hospital to grant Allied Health Staff membership and Privileges or scope of practice only to individuals who meet and maintain the following criteria:

1. Fulfill the objective qualifications for Allied Health Staff membership set forth in Article II.
2. Demonstrate clinical performance and competence with active clinical practice in areas for which Privileges or scope of practice are requested.
3. Demonstrate evidence of skills to provide a type of service that the Governing Body has determined to be appropriate for performance within the Hospital setting and for which a need exists.
4. Demonstrate his/her background, experience and training, current competence, knowledge, judgment, ability to perform, and technique in his/her specialty for all Privileges or scope of practice requested and granted.

5. Not have a physical or mental health concern that impairs his/her ability to safely and effectively fulfill his/her responsibilities of Allied Health Staff membership and the specific Privileges or scope of practice requested by and granted to the applicant, subject to any reasonable accommodation required by law.

6. Have appropriate personal qualifications, to include a record of applicant’s observance of ethical standards including:
   a. Abstinence from receipt of remuneration with respect to referral or patient service opportunities.
   b. A record of working professionally with others within an institutional setting.
   c. Appropriate written and verbal communication skills.

(2) Verification of Information. The primary source verification of references, licensure, certification and other qualifying information shall be conducted by or on behalf of the Hospital. The applicant shall be notified of any problems in obtaining the required information, and it shall be the applicant's responsibility to resolve all such problems.

(3) Completion of Application. The completed application for appointment shall consist of the following:

   (a) A signed application that contains all of the information requested on the application form;

   (b) A signed release from liability form;

   (c) Three (3) letters of reference regarding the applicant's professional experience and competence; one from a Practitioner who has worked with or observed the applicant’s professional work, one from a peer in the same AHP category and one of the applicant’s choosing.

   (d) One signed sponsorship agreement

   (e) Written verification of the applicant's undergraduate and professional education and post-graduate training;
(f) Written verification that the applicant has a current professional license, registration or certificate to practice in the State of Colorado, as applicable to the AHP category;

(g) Written verification of the applicant's professional liability insurance, including limits of liability, extent of coverage, the dates the policy is in effect, and detailed information on malpractice claims history and experience, including suits, judgments and settlements that are pending or concluded;

(h) A statement from the applicant that he/she has no physical or mental health concerns that could affect his/her ability to safely and effectively fulfill the responsibilities of Allied Health Staff membership and perform the Privileges or scope of practice requested;

(i) Written verification that the applicant possesses a current DEA number, if applicable to the Privileges or scope of practice requested;

(j) Any pending or completed action involving denial, revocation, reduction, limitation, probation, non-renewal, or relinquishment of any of the following: license or certificate to practice in Colorado or any other state or any country, appointment or employment status, prerogatives, or privileges or scope of practice at any other hospital, clinic or health care institute or organization;

(k) The Privileges or scope of practice and duties requested;

(l) Verification of applicant's previous or concurrent hospital or other health care institution status and privileges or scope of practice;

(m) A copy of a government issued photo identification;

(n) Any current criminal charges other than minor motor vehicle violations pending against the applicant; any past charges, including their resolution; and any current and past charges involving a drug or alcohol related offense; and

(o) Payment of the required dues.

(3) Submittal of Application. The completed application shall be submitted to the Hospital’s Medical Staff Services Office or designated service along with the applicable dues designated by the Governing Body. After collecting the references and other materials deemed pertinent, the Hospital’s Medical Staff Services Office shall
transmit the application and all supporting materials to the Credentials Committee for evaluation. An incomplete application will not be processed.

(4) **Time Periods.** The time periods for processing an application are guidelines for the Medical Staff leaders and committees, and are not directives that create any rights for an AHP to have an application processed within these precise periods.

**D. Undertakings.** The following undertakings shall be applicable to every Allied Health Staff appointee and applicant for appointment or reappointment as a condition of consideration of such application and as a condition of continued Allied Health Staff appointment if granted:

1. An obligation upon appointment to the Allied Health Staff to provide quality care to all patients within the Hospital within the scope and limits of his/her appointment and as described in Appendix A attached hereto and the privilege or scope forms,

2. An agreement to abide by the terms of all Medical Staff Bylaws and Policies that pertain to Allied Health Staff, including this AHP Manual, all Bylaws and policies of the Hospital, as shall be in force from time to time during the time the individual is appointed to the Allied Health Staff,

3. An agreement to accept non-medical staff committee assignments and such other reasonable duties and responsibilities as shall be assigned to the applicant after appointment by the Governing Body,

4. An agreement to provide the Hospital new or updated information, as it occurs, that is pertinent to any question on the submitted application form,

5. An agreement to abide by the applicable Practitioner supervision requirements,

6. A statement that the applicant has received and had an opportunity to read a copy of this AHP Manual and the Bylaws and other Policies of the Medical Staff and the Hospital as are in force at the time of his/her application and that the applicant has agreed to be bound by the terms thereof, and all amendments thereto from time to time, in all matters relating to consideration of his/her application, without regard to whether or not he is granted appointment to the Allied Health Staff,

7. A statement of the applicant's willingness to appear for personal interviews in regard to his/her application,

8. A statement acknowledging that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall constitute cause for automatic or immediate rejection of the application for appointment and Privileges or scope of practice, which shall not be processed further. In the event that an appointment
has been granted prior to the discovery of a material misrepresentation, misstatement or omission, such discovery may result in automatic suspension of Allied Health Staff membership and Privileges or scope of practice for up to three (3) months and possible corrective action, including termination from the Allied Health Staff or loss of Privileges or scope of practice,

(9) A statement that the applicant will:

(a) Refrain from fee splitting or other inducements relating to patient referral,

(b) Refrain from delegating responsibilities for services to or care of Hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised, and if the Allied Health Staff member is providing services under an order by or the supervision of a Practitioner with Privileges at the Hospital, then such delegation shall only be made with the consent of such Practitioner,

(c) Appropriately identify himself/herself to patients as a provider of the treatment or services for which he has been granted appointment to the Allied Health Staff,

(d) Seek and provide appropriate consultation,

(e) Timely, legibly and accurately complete all medical records,

(f) Abide by generally recognized ethical principles applicable to the applicant's profession,

(g) Provide quality care for the patients in the Hospital within the scope of his/her appointment and as described in Appendix A hereto, as well as in the privilege or scope forms, and

(h) Maintain confidentiality of patient care, quality management and peer review activities.

Each applicant for Allied Health Staff appointment and reappointment shall specifically agree to these undertakings as part of the application.

E. Applicant Interview.

(1) All applicants may be required to participate in an interview(s) as part of the application for appointment to the Allied Health Staff at any point during the credentialing process. Multiple interviews may be required. The interview is to be conducted by Medical Staff, members of the Governing Body and senior management as
selected by the Chair of the body initiating the interview request. A permanent record of the interview will be documented, but will not be a transcript. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., malpractice history, reasons for leaving past health care organizations, or other matter bearing on the applicant’s ability to render care at the generally recognized level for the community. The AHP is not entitled to the due process rights under Article II, Section F in connection with an interview.

(2) The Medical Staff Office or other administrative department will coordinate scheduling of interviews. The interview will be scheduled as soon as practical for both the interviewers and the applicant. It is the responsibility of the applicant to contact the Medical Staff Coordinator after he/she has been notified of the desire for an interview with dates he/she is available. There is no guarantee that the initial dates provided can be accommodated.

(3) Following the interview, the feedback from the interview will be forwarded to the body initiating the request for the interview.

F. Department Chair Action

(1) All completed applications are presented to the Department Chair for review, interview, and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and ability to perform the Privileges or scope of practice requested, including training, experience and current clinical competence, and shall document his/her review. The Department Chair may obtain input if necessary from an appropriate subject matter expert. If a review by a subject matter expert is requested, the time frames established herein may be delayed up to 60 days. The Department Chair takes action as follows:

(a) Deferral: Department Chair may not defer consideration of a completed application. In the event a Department Chair is unable to formulate a recommendation for any reason within the established time-frame, he/she shall forward a report without a recommendation. The applicant will be notified if consideration is delayed because a subject matter expert is being consulted. The Credentials Chair or Credentials Committee will consider the application without Department Chair recommendation, unless delayed for review by subject matter expert.

(b) Favorable recommendation: The Department Chair must document his/her findings pertaining to adequacy of education, training and experience for all Privileges or scope of practice requested. Reference to any criteria for Privileges or scope of practice must be documented and included in the credentials file.
When the Department Chair’s recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the Credentials Chair or Credentials Committee.

(c) Favorable recommendation with conditions: The Department Chair must document his/her findings pertaining to adequacy of education, training and experience for all Privileges or scope of practice requested. Reference to any criteria for Privileges or scope of practice must be documented and included in the credentials file. The Department Chair must also note the conditions of the appointment. For purposes of this Manual, “conditions” are not “Adverse Actions” as defined in this AHP Manual. When the Department Chair’s recommendation is favorable, but conditions apply, the application shall be promptly forwarded, together with all supporting documentation, to the Credentials Chair or Credentials Committee.

(d) Recommendation for Adverse Action: The Department Chair will document the rationale for all unfavorable findings when he/she recommends an Adverse Action. Reference to any criteria for Privileges or scope of practice not met will be documented and included in the credentials file. The application, along with the Department Chair’s recommendation for Adverse Action and supporting documentation, will be forwarded to the Credentials Committee. A Department Chair’s unfavorable findings or recommendation shall not be cause for due process rights under Article I, Section C.

G. Credentials Committee Action.

(1) Review by Committee. The Credentials Committee shall review the completed application, the supporting documentation, and any other relevant information within one hundred twenty (120) days of receiving it. The Credentials Committee may, in its discretion, conduct an interview with the applicant.

(2) Additional Information/Deferral. If the Credentials Committee requires further information, it may defer its deliberations, but generally not for more than forty-five (45) days, except for good cause, and it must notify the applicant in writing via certified mail, return receipt requested, of the deferral and the grounds for it. If the applicant is to provide additional information or a specific release/authorization to allow Hospital representatives to obtain further information, then this request must be included in this notice along with time limits for a response. If the applicant fails, without good cause, to respond in a satisfactory manner by the due date, then this action will be deemed a voluntary withdrawal of the application.
(3) **Physical or Mental Examination.** The Credentials Committee may require any applicant currently seeking appointment or reappointment to procure a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee to aid it in determining whether the applicant has a physical or mental health concern that may impact his/her ability to safely and effectively fulfill his/her responsibilities of Allied Health Staff membership and Privileges or scope of practice. The applicant shall make results available for the Credentials Committee's consideration. Failure of an applicant seeking appointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee or failure timely to make the results of such examination available to the Credentials Committee shall constitute a voluntary withdrawal of his/her application and relinquishment of all Allied Health Staff membership and Privileges or scope of practice until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

**H. Effect of Credentials Committee Action.** The following initial actions can be taken by the Credentials Committee:

1. **Deferral.** The Credentials Committee may defer the application for further consideration, which deferral must, except for good cause, be followed up within forty-five (45) days with the Credentials Committee's report and recommendations for either appointment to the Allied Health Staff or rejection for appointment. The Chief Executive Officer must be so informed and must send the applicant written notice, via certified mail, return receipt requested, concerning the action to defer, including a request for the specific data/explanation or release/authorization if any is required from the applicant and the time limit for response. Failure without good cause to respond in a satisfactory manner by the due date shall be deemed a voluntary withdrawal of the application.

2. **Favorable Recommendation.** If the Credentials Committee's initial recommendation is favorable, then the favorable recommendation will be forwarded to the Medical Executive Committee.

3. **Adverse Recommendation.** If the Credentials Committee's initial recommendation is adverse, this recommendation will be forwarded to the Medical Executive Committee. The Credential’s Committee’s unfavorable findings or recommendation shall not be cause for due process rights under Article I, Section C.

**I. Medical Executive Committee Action:** The following initial actions can be taken by the Medical Executive Committee:

1. **Deferral.** The Medical Executive Committee may defer the application for further consideration, which deferral must, except for good cause, be followed up within forty-five (45) days with the Medical Executive Committee's report and recommendations for either appointment to the Allied Health Staff or rejection for appointment. The Chief Executive Officer must be so informed and must send the
applicant written notice, via certified mail, return receipt requested, concerning the action to defer, including a request for the specific data/explanation or release/authorization if any is required from the applicant and the time limit for response. Failure without good cause to respond in a satisfactory manner by the due date shall be deemed a voluntary withdrawal of the application.

(2) **Favorable Recommendation.** If the Medical Executive Committee's initial recommendation is favorable, then the favorable recommendation will be forwarded to the Governing Body.

(3) **Adverse Recommendation.** If the Medical Executive Committee's initial recommendation is adverse, the Chief Executive Officer shall promptly inform the applicant of the recommendation by written notice via certified mail, return receipt requested, of the recommendation. The applicant may request due process rights in accordance with Article II, Section F, if he/she has not waived or exhausted such rights. Following the waiver or exhaustion of due process rights, the Medical Executive Committee recommendation and results of due process rights shall be forwarded to the Governing Body.

**J. Governing Body Action.** The Governing Body may, at its sole discretion, conduct an interview with the applicant. If, as part of its deliberations, the Governing Body determines that it requires further information, it may defer action, but generally for not more than sixty (60) days, except for good cause, and it shall notify the applicant in writing via certified mail, return receipt requested, of the deferral and the grounds for it. If the applicant is to provide additional information or a specific release/authorization to allow Hospital representatives to obtain information, a written notice to him must so state and must include a request for the specific data/explanation or release/authorization required and state the time limit for response. Failure by the applicant, without good cause, to respond in a satisfactory manner by the due date shall be deemed a voluntary withdrawal of the application.

(1) **Upon Favorable Medical Executive Committee Recommendation:** The Governing Body may adopt or reject, in whole or in part, a favorable Credentials Committee recommendation or refer the recommendation back for further consideration, stating the reasons for such referral back and setting a time limit within which a reconsidered recommendation must be returned to the Governing Body.

a) If the Governing Body's action is favorable to the applicant, it shall be effective as its final decision. All appointments to the Allied Health Staff and granting of Privileges or scope of practice are for a period not to exceed 24 months.

b) If the Governing Body's action is adverse to the applicant in any respect, the Chief Executive Officer shall promptly inform the
applicant of the decision by written notice via certified mail, return receipt requested, of the Governing Body's decision. The applicant may request due process rights in accordance with Article II, Section F, if he/she has not waived or exhausted such rights. Following the waiver or exhaustion of due process rights, the Governing Body may uphold or modify its determination, which shall be final.

**K. The Provisional Allied Health Staff**

i) All initial appointments of practitioners to the Allied Health Staff shall be to the Provisional category of the Staff, and such appointment shall be for a period of no less than one (1) year.

ii) During this provisional period, the Allied Health Staff member's performance will be evaluated by the Quality Management and Peer Review Committees, as such Committees may deem necessary, with any findings or concerns being forwarded to the Credentials Committee for review and consideration for the Member's advancement to regular Allied Health Staff membership.

iii) If at the end of this provisional period an Allied Health Staff member fails to advance to the status of regular membership, his/her provisional status may be continued by the Credentials Committee for up to twelve (12) additional months. At the end of such period, the Quality Management and Peer Review Committees, as such Committees may deem necessary, will submit their written findings to the Credentials Committee for review and consideration for the member's advancement to regular Allied Health Staff membership. Thereafter, the procedure specified in this AHP Manual shall be followed. If at the end of this additional period an Allied Health Staff member fails to advance to the status of regular membership, his/her Allied Health Staff membership will not be renewed. In such event, the member shall have the rights accorded by this AHP Manual to a member who is not reappointed to Allied Health Staff membership.

iv) **Without Benefit of Credentials Committee Recommendation:** The following procedures shall be followed if the Governing Body in its determination does not receive a recommendation from the Credentials Committee during the time frame provided for or within any reasonable extension of any time frame resulting from a deferral of a recommendation in order to obtain additional data/explanation or a specific release/authorization, or for any other good cause. The Governing Body may, after notifying the Medical Executive Committee of its intent, including a reasonable period of time for response, take action on its own initiative, employing the same type of information usually considered by the Medical Executive Committee. Favorable action by the Governing
Body shall be effective as its final decision. If the Governing Body's action is adverse to the applicant in any respect, the Chief Executive Officer shall promptly inform the applicant of the decision by written notice via certified mail, return receipt requested, of the Governing Body's decision. The applicant may request an appearance before the Credentials Committee in accordance with Article II, Section F, if he/she has not waived or exhausted his/her right to an appearance. The Governing Body shall review the report of the Credentials Committee following the appearance and may uphold or modify its determination in its sole discretion.

L. Reappointment Procedures - the Reappointment Application.

(1) Completion of Application. After the initial appointment to the Allied Health Staff, every two years prior to the Allied Health Staff member's birthday, the Medical Staff Services Office shall cause an application for reappointment to be sent to such Allied Health Staff member. Primary source verification shall be performed, if possible, with regard to each Allied Health Staff member applying for reappointment. Within thirty (30) days of receipt of the application, the Allied Health Staff member shall furnish the following in writing, on the application for reappointment approved by the Governing Body:

(a) Complete information and all documents necessary to bring his/her file up to date on the items listed in section II.D. above, including verification of current state license, registration, or certification, professional liability insurance coverage and experience, other institutional affiliations and status, disciplinary actions pending or completed since the last application, and health status changes;

(b) Information concerning continuing training and education external to the Hospital during the preceding appointment period;

(c) Specific requests for additions to, or deletions from, the Privileges or scope of practice and duties presently held, with any basis for changes;

(d) A number of patient encounters at the Hospital;

(e) Peer references;

(f) A recommendation by the sponsoring Practitioner, or another Practitioner who has worked with the applicant;

(g) Any additional review as deemed necessary by the Department Chair;

(h) Payment of the required dues; and
(i) The Allied Health Staff member must sign the reappointment application and in so doing accepts the conditions as stated in section II above in connection with the initial application.

(2) Request for Extension of Time Limit. If the Allied Health Staff member has not returned his/her completed application for reappointment, with all of the required information, or requested an extension for good cause within the required thirty (30) days, such failure shall be deemed a voluntary resignation from the Allied Health Staff and shall result in automatic termination of appointment at the expiration of his/her current term.

(3) Informational Inadequacies or Verification Problems. The Medical Staff Services Office shall have verified the information provided on the reappointment application, and notify the Allied Health Staff member of any informational inadequacies or verification problems. This must indicate the nature of the additional information the Allied Health Staff member is to provide and the time limits for response. Failure, without good cause, to respond in a satisfactory manner by the due date shall be deemed a voluntary withdrawal of the application for reappointment.

(4) Information from Hospital Staff. Hospital staff that work with or have information relating to the practice of Allied Health Staff members will be solicited for input regarding the performance of the applicant.

(5) Completed Reappointment Application. The Medical Staff Services Office shall transmit the completed reappointment application to the Department Chair.

M. Department Chair Action. All completed applications for reappointment shall be submitted to the Department Chair. The Department Chair shall review and act upon reappointment applications in the same manner as initial appointment applications (Article III, Section F above).

N. Credentials Committee Action.

(1) Basis of Reappointment. The Credentials Committee shall review and evaluate the reappointment application along with the following additional information regarding each applicant's professional and collegial activities, performance and conduct in the Hospital. This additional information shall include:

(a) Professional competence, performance, judgment, patterns of care and utilization as demonstrated in the findings of quality management, risk management and utilization management activities;

(b) Participation in relevant continuing education activities in the amount of an average of twenty hours a year over a two year reappointment cycle;
(c) Clinical activity at the Hospital;

(d) Sanctions imposed or pending and other problems;

(e) Health status;

(f) Attendance at required Allied Health Staff and Allied Health Committee meetings;

(g) Timely and accurate preparation and completion of medical records;

(h) Cooperativeness in working with Medical Staff, other AHPs and Hospital personnel;

(i) General attitude and behavior toward patients, the Hospital, Medical Staff, other AHPs, Hospital staff and the public;

(j) Compliance with this AHP Manual and all applicable Bylaws, Policies, and rules and procedures of the Hospital and Allied Health Staff; and

(k) Any other pertinent information that may be deemed relevant to the Allied Health Staff member's status and Privileges or scope of practice at the Hospital, including the Allied Health Staff member's activities in other hospitals and his/her practice outside the Hospital.

The application along with the additional information mentioned above shall form a basis for recommendations for reappointment from the Credentials Committee.

(2) **Request for Additional Information.** If the Credentials Committee requires additional information, it shall notify the Allied Health Staff member in writing of the information required. If the Allied Health Staff member is to provide the additional information himself/herself, the notice to him must be a written notice and must include a request for the specific information required and the time limits for response. Failure without good cause to respond in a satisfactory manner by the time specified shall be deemed a voluntary withdrawal of the reappointment application.

(3) **Physical or Mental Examination.** The Credentials Committee may require any applicant currently seeking appointment or reappointment to procure a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee to aid it in determining whether the applicant has a physical or mental health concern that may impact his/her ability to safely and effectively fulfill his/her responsibilities of Allied Health Staff membership and privileges or scope of practice. The applicant shall make results available for the Credentials Committee's consideration. Failure of an applicant seeking appointment to procure such an
examination within a reasonable time after being requested to do so in writing by the Credentials Committee or failure timely to make the results of such examination available to the Credentials Committee shall constitute a voluntary withdrawal of his/her application and relinquishment of all Allied Health Staff membership and Privileges or scope of practice until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

(4) **Inadequate Clinical Activity.** If the Allied Health Staff member’s level of clinical activity at the Hospital is not sufficient to permit the Credentials Committee, Medical Executive Committee or Governing Body to make an informed judgment as to his/her competence in exercising the Privileges or scope of practice requested, the Allied Health Staff member shall have the burden of providing evidence of clinical performance at his/her principal institution in such form as may be required by the committee or the Governing Body. Additionally, if, in the discretion of the Governing Body, there has been inadequate demand for or activity in a given Allied Health Staff category during any 1-year period, the Governing Body may, on such basis alone, not renew an applicant’s reappointment application or may delete the Allied Health Staff category altogether.

(5) **Recommendations.** The Credentials Committee shall prepare a written recommendation for, and any special limitations on, reappointment or non-reappointment, and requested Privileges or scope of practice. If no such recommendations are made, the reasons therefore must be stated. The Credentials Committee report shall be transmitted along with all supporting documentation, as required, to the Medical Executive Committee.

O. **Medical Executive Committee Action**

(1) **Action.** The Medical Executive Committee shall review and act upon reappointment recommendations from the Credentials Committee in the same manner as initial appointment application recommendations (Article III, Section I above).

P. **Governing Body Action.**

(1) **Action.** The Governing Body shall review and act upon reappointment recommendations from the Medical Executive Committee in the same manner as initial appointment application recommendations (Article III, Section J above). All reappointments to the Allied Health Staff and renewal of Privileges or scope of practice are for a period not to exceed 24 months.

Q. **Reapplication after Adverse Decision.** Except as otherwise provided for in this AHP Manual or as determined by the Credentials Committee in light of exceptional circumstances, an applicant or Allied Health Staff member who has received an adverse
decision regarding appointment, reappointment or Privileges or scope of practice is not eligible to reapply for Allied Health Staff membership or for the denied Privileges or scope of practice for a period of one (1) year from the date of the notice of the final adverse decision. Any such reapplication shall be processed as an initial application in accordance with the procedures set forth in Article III above. The applicant or Allied Health Staff member must submit such additional information as the Credentials Committee may require in demonstration that the basis of the earlier adverse action no longer exists. If such information is not provided, the application will be considered incomplete and voluntarily withdrawn and will not be processed further.

R. **Summary Suspension of Privileges.** The Privileges or scope of practice of an Allied Health Staff member may be suspended according to the following procedure.

(1) **Grounds for Summary Suspension.** The Chairman of the Credentials Committee, the Chief of Staff, the Chief Executive Officer, or in his/her absence his/her designee, or the Chairman of the Governing Body shall each have the authority to summarily suspend all or any portion of the Privileges or scope of practice of a Allied Health Staff member when failure to take such action may result in danger to the health of any individual. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension. Such summary suspension shall become effective immediately upon an Allied Health Staff member, and shall immediately be reported in writing to the Chairman of the Governing Body, the Chief Executive Officer, the Chief of Staff, the Chairman of the Credentials Committee and via certified mail, return receipt requested, to the affected Allied Health Staff member, and shall remain in effect unless or until modified by the Chief Executive Officer, the Credentials Committee or the Governing Body.

(2) **Credentials Committee Procedure.** Any person who exercises authority under paragraph (1) above to summarily suspend Privileges or scope of practice shall immediately report this action to the Chairman of the Credentials Committee to take further action in the matter. An investigation of the matter resulting in summary suspension shall be completed as soon as practical, ordinarily within thirty (30) days of the suspension or reasons for the delay shall be transmitted to the Governing Body so that it may consider whether the suspension should be lifted. If the Governing Body does not lift the summary suspension or if the summary suspension is lifted but further action is warranted, the matter will be referred to the Credentials Committee for further investigation and recommendation. If the Governing Body does not lift the summary suspension, it shall remain in force unless and until modified by the Credentials Committee, the Chief Executive Officer or the Governing Body, or until the matter that required the suspension is finally resolved. The CEO and Governing Body may request input from the Medical Executive Committee in considering their decision. The AHP under suspension may request due process rights in accordance with Article III, Section F, if he/she has not waived or exhausted such rights. Following the waiver or exhaustion of due process rights, the Governing Body shall uphold or modify the suspension, and its determination shall be final.
S. **Automatic Suspension or Termination.** Actions or inaction in the following specified areas shall automatically result in the voluntary suspension or termination of Privileges or scope of practice and AHP status without recourse:

1. **Failure to Complete Medical Records.** The Privileges or scope of practice of any Allied Health Staff member shall be voluntarily suspended for failure to complete medical records in accordance with the requirements of Appendix A hereto or applicable policies, after notification by the medical records department of such delinquency. Such suspension shall continue until all the records are no longer delinquent. Failure to complete the records within thirty (30) days of notice by the medical records department the medical records that caused suspension of Privileges or scope of practice shall constitute a voluntary relinquishment of all Privileges or scope of practice and resignation from the Allied Health Staff.

2. **Action by State Licensing Agency.** Action by the appropriate state licensing, registration or certifying board or agency revoking or suspending an individual's license registration or certificate (including DEA certificate, if applicable), or loss or lapse of state license registration or certificate to practice for any reason, shall result in automatic suspension and termination in accordance with Article II, Section D above.

3. **Failure to be Adequately Insured.** If at any time an Allied Health Staff member's professional liability insurance coverage lapses, falls below the minimum required by the Governing Body as described in policies as adopted by the Governing Body, is terminated or otherwise ceases to be in effect (in whole or in part), this shall result in automatic suspension and termination in accordance with Article II, Section D above.

T. **Confidentiality and Reporting.** This AHP Manual is incorporated by reference into, and made a part of, the Hospital’s Quality Management Plan, as such is amended from time to time. All records, reports, minutes, statements and other information generated through the processes described in this AHP Manual and the Quality Plan are intended to be privileged and confidential to the greatest extent possible under applicable Colorado and federal law, including without limitation, the Colorado Hospital Licensing Statute, C.R.S. §25-3-109. Notwithstanding the foregoing, reports of actions taken pursuant to this AHP Manual and the Quality Plan shall be made to appropriate governmental agencies as may be required by law.

U. **Peer Review Protection.** This AHP Manual is incorporated by reference into, and made a part of, the Hospital’s Quality Management Plan, as such is amended from time to time. The Hospital, the Allied Health and other Medical Staff committees and individual participants in the processes described in this AHP Manual and the Quality Plan are intended to be immune from suit and damages to the greatest extent possible under applicable Colorado and federal law, including without limitation, the Colorado Hospital Licensing Statute, C.R.S. §25-3-109.
V. Amendment  This AHP Manual is a Policy of the Medical Staff and shall be approved, adopted and modified in accordance with the Bylaws, as such are amended from time to time. This AHP Manual is incorporated by reference into the Bylaws, as such are amended from time to time.

W. Conflict Resolution. Whenever the Governing Body determines that it will decide a matter contrary to the MEC’s recommendations, the matter will be submitted to a committee of equal members of the MEC and Governing Body for review and recommendation before the Governing Body makes its final decision. The Governing Body chairman shall be authorized to vote in order to break a tie. The committee will submit its recommendation to the Governing Body within forty-five (45) days of submission and such delay in action will not be cause for an appearance under Article II, Section F.
APPENDIX A

CATEGORIES OF ALLIED/COMPLEMENTARY HEALTH STAFF

A. Specific Qualifications and Duties. At the discretion/request of the Chief Executive Officer, Chief of Staff, Chairman of the Allied Health Committee or the Governing Board, any type of Allied Health Professional functionary or proposed functionary may be referred to the Allied Health Committee for review and delineation of allowable qualifications and duties.

The following qualifications, duties and responsibilities are delineated for Allied/Complementary Health Professionals who have been approved by the Governing Body and are on the Allied Health Staff:

(1) Certified Registered Nurse Anesthetists (CRNA). All CRNA's who practice in the Hospital’s facilities shall meet the following qualifications, status and duties:

(a) Qualifications

(i) Graduate of an accredited School of Anesthesia.
(ii) Current certification as a Certified Registered Nurse Anesthetist by the American Association of Nurse Anesthetists.
(iii) Current license as a Registered Nurse by the Colorado State Board of Nursing and recertification by the Council on Recertification of Nurse Anesthetists for Continuing Education.
(iv) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.

(b) Status

(i) The CRNA practices only under the direct supervision of an anesthesiologist who is a member of the Active Medical Staff of the Hospital.
(ii) The CRNA is responsible to the Chief of Anesthesia for providing call coverage, as required, and conducting his practice according to the quality assurance standards established for the Anesthesia Service.
(iii) The CRNA participates directly in the management of anesthesia patients under the direct supervision of an anesthesiologist who is a member of the Active Medical Staff of the Hospital and in accordance with policies and procedures of the Anesthesia Service.
(iv) The CRNA is responsible to the attending surgeon for the anesthesia provided to patients.
(v) All medical records documentation for services performed in the Hospital’s facilities shall be reviewed and countersigned by the Supervising Anesthesiologist at least every two (2) working days.

(c) Duties

(i) Induce, maintain and recover all anesthesia patients.
(ii) Conduct pre-anesthesia survey on all patients who will be anesthetized.
(iii) Perform post anesthesia visits on all patients who were anesthetized.
(iv) All other duties permitted by the State of Colorado, recommended by the Medical Staff and approved by the Governing Body.
(v) The type and extent of supervision by the medical staff will be delineated in the Credentials Committee deliberations.
(vi) The CRNA must participate in the Hospital's Peer Review and Quality Management Programs.
(2) Mental Health Workers (Categories: Psychologists, Social Workers, Marriage and Family Therapists and Licensed Professional Counselors)

(a) Qualifications
(i) Psychologists - licensed as a psychologist by the Colorado State Board of Psychologist Examiners and therefore has met all of the requirements for such licensure set forth in Colorado law.
(ii) Social Workers - licensed as a social worker by the Colorado State Board of Social Work Examiners and therefore has met all the requirements for licensure as set forth in Colorado law.
(iii) Marriage and Family Therapist - licensed as a marriage and family therapist by the Colorado State Board of Marriage and Family Therapist Examiners and therefore has met all the requirements for licensure as set forth in Colorado law.
(iv) Licensed Professional Counselor - licensed as a Licensed Professional Counselor and therefore has met the requirements for such licensure as set forth in Colorado law.
(v) Licensure requirements may be waived if the Mental Health Worker is employed or contracted through an agency licensed by the state of Colorado.

(b) Status
(i) Responsible to the Medical Director of Quality Services of the Hospital for all professional services provided in accordance with the quality assurance standards established by the Behavior Sciences Services and for all administrative matters, including providing call coverage.
(ii) Accurately and timely document the care provided to the patient within the medical record, upon the designated Complementary Progress Note.

(c) Duties
Providing professional mental health services within the reasonable and customary limits of their category as defined by the Colorado Mental Health Licensing Statute recommended by the Allied Health Committee and approved by the Governing Body. All mental health workers must participate in the Hospital's Peer Review and Quality Management Programs.

(d) The Mental Health provider is not required to have a sponsoring physician, and may practice with no supervision.

(3) Registered Nurse/First Assistant (RNFA)

(a) Qualifications
RNFA's must meet all of the following qualifications before being permitted to function in the expanded role of First Assistant:
(i) Current Colorado license.
(ii) Three (3) years experience as an RN in the operating room.
(iii) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.
(iv) Certified in Perioperative Nursing (CNOR).
(v) CPR (ACLS) certified.
(vi) Successful completion of didactics of structured course in first assisting.
(vii) Validation of the necessary clinical skills by an internship with a member of the surgical staff as mentor.
(viii) Participation in continuing education activities for their profession.

(b) **Status**
(i) The RNFA practices only under the direct supervision of the surgeon during the surgical intervention.
(ii) The RNFA must perform only as first assistant and not concurrently as scrub nurse, and as such, shall not make entry into the medical record.
(iii) The RNFA will be evaluated annually after the first year, by physician-surgeons requesting the RNFA's assistance.
(iv) During the reappointment process, the RNFA shall submit three (3) peer reviews by surgeons (MD) with whom the RNFA has operated during the previous year. Additionally, peer review may take place periodically as necessary and desirable.
(v) RNFA reimbursement schedules and practices are subject to evaluation and agreement by Hospital Administration.

(c) **Duties**
(i) The RNFA must adhere to the policies of Yampa Valley Medical Center and must remain within the scope of practice as stated by the Nurse Practice Act of the State of Colorado.
(ii) The RNFA shall perform only those procedures which are specifically approved by the Allied Health Committee.
(iii) Only in extreme emergencies should an RNFA be expected to assist on procedures that present an unusual hazard to life.
(iv) The RNFA must participate in the Hospital's Peer Review and Quality Management Programs.

(4) **Physician Assistants (PA).**

(a) **Qualifications**
(i) Baccalaureate Degree.
(ii) Graduate of CAHEA approved PA program.
(iii) Successful completion of NCC PA examination.
(iv) Current Colorado license.
(v) Current registration as a Physician Assistant with the Colorado State Board of Medical Examiners.
(vi) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.
(vii) BLS certified.
(viii) Participation in continuing education activities for their profession.

(b) **Status**
(i) The PA practices only under the supervision of the appointed Medical Staff Member who shall serve as the PA's Physician Supervisor pursuant to written agreement. The supervising physician must be able to be with the P.A. within 20 minutes.
(ii) All medical records documentation for services performed in Yampa Valley Medical Center shall be reviewed and countersigned by the Supervising Physician at least every two (2) working days.

(c) **Duties**
(i) The PA must comply with all policies and rules and regulations of Yampa Valley Medical Center and the Rules and Regulations of the
Colorado State Board of Medical Examiners as they relate to PA practice (copies are available in Medical Staff Services Office), and must remain within the scope of practice as defined in the Colorado Medical Practice Act and applicable Rules and Regulations.

(ii) Perform initial and ongoing assessment of patients' medical, physical and psychosocial status.
(iii) Implement physician-directed treatment plans.
(iv) The PA must participate in the Hospital's Peer Review and Quality Management Programs.

(5) **Advanced Practice Nurses**

(a) **Qualifications**
(i) Current active licensure as a Professional Nurse by the Colorado State Board of Nursing.
(ii) Bachelor of Science degree in Nursing.
(iii) Graduation and Certification as a Nurse Practitioner.
(iv) Current registration as a Nurse Practitioner with Colorado State Board of Nursing.
(v) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.
(vi) Participation in continuing education activities for their profession.

(b) **Status**
(i) The Advanced Practice Nurse practices only under the direct supervision of the sponsoring Physician, pursuant to written agreement.
(ii) All medical records documentation for services performed in Yampa Valley Medical Center shall be reviewed and countersigned by the sponsoring Physician at least every two (2) working days.

(c) **Duties**
(i) The Advanced Practice Nurse must comply with all policies and rules and regulations of Yampa Valley Medical Center and the Rules and Regulations of the Colorado State Board of Nursing as they relate to Advanced Practice Nurse practice (copies are available in Medical Staff Services Office).
(ii) The Advanced Practice Nurse shall perform only those procedures which are specifically approved in advance by the Allied Health Committee.
(iii) Categories of duties are further defined by specialty, as designated by the Allied Health Committee.
(iv) The Advanced Practice Nurse must participate in the Hospital's Peer Review and Quality Management Programs.

(6) **Dental Hygienists.**

(a) **Qualifications**
(i) Current Colorado State licensure and all qualifications required by the Colorado Division of Regulatory Agencies.
(ii) Current Professional Liability Insurance in the amount of $1,000,000 per occurrence and $3,000,00 annual aggregate.
(iii) Letters of recommendation from two (2) professionals who have personal knowledge of the competence of the dental hygienist.
(iv) Participation in continuing education activities for their profession.
(b) **Status**

(i) Dental hygienist shall function as a licensed independent professional under contractual agreement with the Hospital to provide dental hygiene services under the supervision of a physician or dentist who is a member of the Active Medical Staff. The dentist must be available to the Hygienist within 20 minutes. The dental Hygienist’s duties and activities shall be monitored by the Hospital’s Human Resources Department.

(ii) Diagnosis of underlying medical conditions must be established by the supervising physician, and upon initial consultation, the dental hygienist must be informed of all pertinent medical and dental history.

(iii) Accurately and timely document care provided to the Patient/resident within the medical record, upon the designated Complementary Progress Note.

(c) **Duties**

(i) The dental hygienist must participate in the Hospital’s Peer Review and Quality Management Programs.

(ii) With satisfactory documentation of current clinical competence, the dental hygienist may administer local anesthetics and nitrous oxide/oxygen analgesia.

(iii) The directing physician or dentist shall be notified as soon as possible of any complications from treatment provided or the need for additional dental treatment.

(7) **Acupuncturists.**

(a) **Qualifications**

(i) Current active registration as an Acupuncturist with the Director of the Division of Registrations in the Department of Regulatory Agencies for the State of Colorado.

(ii) Educational degree as required by the Director of the Division of Registrations.

(iii) All qualifications required by the Director of the Division of Registrations, C.R.S. §§12-29.5-101 et seq. and the Rules and Regulations promulgated by the Director of the Division of Registrations.

(iv) Successful completion of all portions of the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) examination in acupuncture including, without limitation, acupuncture, clean needle technique and practical examination of point location skills.

(v) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.

(vi) Letters of recommendation from two (2) professional peers who have personal knowledge of the applicant’s competence in acupuncture.

(vii) Participation in continuing education activities for their profession.

(b) **Status**

(i) The Acupuncturist shall provide acupuncture services on protocol supervision on the written order of a physician who is a member of the Active or Associate Medical Staff. All treatment protocols will be submitted by the acupuncturist and approved by the Credentials Committee, the MEC and the Governing Board.
(ii) The Acupuncturist practices only under the direction of a physician who is a member of the Active/Associate Medical Staff of the Hospital. Physician acupuncturists may practice independently if they are members of the Active or Associate Medical Staff of the Hospital.

(iii) Diagnosis of underlying medical conditions must be established by the directing physician, and upon initial consultation, the Acupuncturist must be informed of all pertinent medical history of the patient.

(iv) Acupuncture reimbursement schedules and practice shall be subject to evaluation and agreement by Hospital administration.

c) Duties

(i) The Acupuncturist must participate in the Hospital's Peer Review and Quality Management Programs.

(iii) The directing physician will have ultimate medical responsibility for the patient and therefore perform all the attendant duties, including admission history and physical examination and discharge summary at the end of hospitalization.

(iv) Details of treatment are at the discretion of the Acupuncturist. The Acupuncturist will make entries into the patient medical record with pertinent treatment information each time they visit the patient in the Hospital.

(v) The Acupuncturist shall report promptly to the directing physician, if requested, the method of acupuncture treatment and the results of such treatment together with such other information as the directing physician requires to maintain the records regarding acupuncture treatment.

(vi) The directing physician shall be notified as soon as possible of any complications of acupuncture treatment that may have occurred.

(vii) The Acupuncturist must clearly indicate that he/she is an acupuncturist to individuals being treated. The Acupuncturist must at all times, when administering acupuncture treatments, wear a name tag with the designation "Acupuncturist" thereon.

(viii) The Acupuncturist must at all times comply with the requirements of C.R.S. §§12-29.5-101 et seq.

(8) Surgical First Assistants

A. Registered Nurse/First Assistants (See Appendix, section A(3) of the Policy Manual)

B. Physician Assistants (See Appendix, section A(4) of the Policy Manual, plus documentation of current competence and prior experience as required below for Surgical First Assistants.)

C. Certified Surgical Technologists - First Assistant

(a) Qualifications

(i) Training in a program that runs at least nine (9) months or 900 hours and is divided between clinical and classroom education and is accredited by the Committee on Allied Health Education and Accreditation or another avenue of entry otherwise acceptable to the Liaison Council on Certification for Surgical Technologists.

(ii) Current certification for Surgical Technologists.

(iii) Maintain certification by accruing 72 hours of approved continuing education in a consecutive six (6) year period or by successfully retaking the certification examination at the conclusion of the six-year period.
(iv) Validation of the necessary skills by an internship with a surgical member of the Active Medical Staff as a mentor.
(v) Two (2) letters of recommendation: from (1) a surgeon directly familiar with the applicant’s competence, and (2) a letter from a peer or program director attesting to the applicant’s competence.
(vi) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.

(b) Status
(i) The Surgical Technologist-First Assistant shall function as an employee of or via a contractual agreement with a Physician member of the active Medical Staff of the Hospital. If they are an employee of a physician, they shall practice only under the supervision of that physician and shall not be available to assist other surgeons unless specific supervising arrangements have been made. A letter of this agreement shall be kept on file.
(ii) The Surgical Technologist-First Assistant practices only under the direct supervision of the surgeon during the surgical intervention.
(iii) The Surgical Technologist-First Assistant will be evaluated at least annually by the sponsoring physician and by the operating room supervisor. The Surgical Technologist-First Assistant’s reimbursement schedules and practices may be subject to evaluation and agreement by Hospital Administration.

(c) Duties
(i) The Surgical Technologist-First Assistant must adhere to the policies of the Hospital and must function only within the scope of practice as stated by their certifying board. The ST-FA will be under the direct supervision of the operating surgeon.
(ii) The Surgical Technologist-First Assistant shall function as an intraoperative first assistant and shall not make patient assessments, write or dictate notes or orders or attend to patients other than in the course of a surgical procedure.
(iii) Only in extreme emergencies should a Surgical Technologist-First Assistant be expected to assist on procedures that present an unusual hazard to life.

(9) Orthopaedic Technologists - Surgery Certified (OT-SC)

(a) Qualifications
(i) Certification by the National Board for Certification of Orthopaedic Technologists with the required additional certification as surgical assistant (orthopaedic technologist- surgery certified).
(ii) Validation of necessary skills by an internship with a surgical member of the Active Medical Staff as a mentor.
(iii) Two (2) letters of recommendation: from (1) a surgeon directly familiar with the applicant’s competence, and (2) a letter from a peer or program director attesting to the applicant’s competence.
(iv) Maintain certification and recertification by obtaining 180 hours during each 6-year certification period which are submitted and approved as required by the National Board of Certified Orthopaedic Technologists. Also, a letter attesting to the clinical competence will be submitted each year by the sponsoring surgical member of the Active Medical Staff.
(vi) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.
(b) **Status**  
(i) The OT-SC shall function as an employee of or via a contractual agreement with a Physician member of the active Medical Staff of the Hospital. If they are an employee of a physician, they shall practice only under the direct supervision of that physician and shall not be available to assist other surgeons unless specific supervising arrangements have been made. A letter of this agreement shall be kept on file.  
(ii) The OT-SC practices only under the direct supervision of the surgeon during the surgical intervention.  
(iii) The OT-SC will be evaluated at least annually by the sponsoring physician and by the operating room supervisor.  
(iv) The OT-SC’s reimbursement schedules and practices may be subject to evaluation and agreement by Hospital Administration.

(c) **Duties**  
(i) The OT-SC must adhere to the policies of the Hospital and must function only within the scope of practice as stated by their certifying board.  
(ii) The OT-SC shall function as an intraoperative first assistant and shall not make patient assessments, write or dictate notes or orders or attend to patients other than in the course of a surgical procedure.  
(iii) Only in extreme emergencies should the OT-SC be expected to assist on procedures that present an unusual hazard to life.

(10) **Massage Therapists**

(a) **Qualifications**  
(i) Minimum of 500 hours in formal training at an established, state licensed school of massage and/or body work that is accredited or approved by the Commission on Massage Training Accreditation with successful completion of the program.  
(ii) Included in the program must be a minimum of 100 hours in anatomy/physiology, 200 hours in massage therapy and 200 hours in related studies.  
(iii) Proof of completion of program in the form of official transcription and diploma or certificate of completion.  
(iv) Must be nationally certified by the national Certification Board for Therapeutic Massage and Body Work (NCBTMB).  
(v) Must have documented completion of 50 hours of continuing education or recertification every 4 years.  
(vi) Letters of recommendation from 2 professional peers who are knowledgeable with your competence in massage therapy.  
(vii) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.  
(viii) Participation in continuing education activities for their profession.

(b) **Status**  
(i) The Massage Therapist shall provide massage therapy services only on the written order of a physician who is a member of the Active or Associate Medical Staff.  
(ii) The Massage Therapist practices only under the direction of a physician who is a member of the Active or Associate Medical Staff.  
(iii) Diagnosis of underlying medical conditions must be established by the
ordering physician and upon initial consultation, the Massage Therapist must be informed of all pertinent medical history.

(iv) Reimbursement for Massage Therapy services is the responsibility of the Massage Therapist. Reimbursement schedules and practice may be subject to evaluation and agreement by Hospital Administration.

(v) Massage Therapy services may take place in 15 minute intervals to a maximum of 1 hour for any given patient per day.

(vi) Massage Therapy services shall only be available to inpatients at Yampa Valley Medical Center and Doak Walker Care Center (excludes outpatients).

c) Duties

(i) The Massage Therapist shall be required to participate in the Hospital’s peer review and quality management programs.

(ii) The Massage Therapist shall perform only the procedures requested on the written order of the ordering physician.

(iii) Details of treatment are at the discretion of the Massage Therapist. The Massage Therapist will make entries into the patient medical record with (complementary services form) pertinent treatment information each time they visit the patient in the Hospital.

(iv) The ordering physician shall be notified as soon as possible of any complications of Massage Therapy treatment.

(v) The Massage Therapist must clearly indicate that he/she is a Massage Therapist to the individuals being treated and wear a name tag with the designation “Massage Therapist” thereon.

11) Certified Nurse Midwives (CNMW)

(a) Qualifications

(i) Current Colorado Registered Nurse Licensure and registered by the State of Colorado as an Advanced Practice Nurse.

(ii) Graduate of a Nurse-Midwifery program accredited by the American College of Nurse-Midwives (ACNM); successful completion of the certification exam and receipt of certification by the ACNM in Nurse-Midwifery.

(iii) Demonstrate prior performance of at least 30 deliveries in the past 24 months or applicable recent experience as a certified nurse-midwife.

(iv) Current CPR certification and NRP (Neonatal Resuscitation Program) certification.

(v) Current professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.

(vi) Proven competence to assume responsibility for management of obstetric care and subsequent follow-up care of women whose medical and obstetrical history indicates a normal prospectus.

(vii) Evidence of continued education as required by the American College of Nurse-Midwives.

(viii) Proof of a clinical practice relationship by a written agreement with an OB/Gyn member of the Active Medical Staff that provides a clear understanding of their individual, collaborative and interdependent responsibilities and adheres to the practice parameters outlined in the description of Duties in this Section 11 and in the Policy Manual and in the privilege request form relevant to privileges requested and current clinical competence. A copy of the written agreement shall be provided to the Allied Health Committee.

(b) Status

(i) CNMW shall provide obstetrical care for healthy women following
approved and agreed upon written medical guidelines/protocols for clinical practice which define the individual and shared responsibilities of the CNMW and the sponsoring Active Medical Staff Ob/Gyn in the delivery of health care services.

(ii) Consultation and joint patient management involving both the CNMW and the sponsoring Active Medical Staff Ob/Gyn is required for women who experience medical, obstetrical or gynecological complications of any kind.

(iii) The CNMW must participate in periodic and joint evaluation of services rendered, including participation in chart review, patient evaluation and outcome review, as well as participate in the Quality Management and Peer Review processes at the Hospital.

(c) Duties
The duties performed by the CNMW may include the following when registration and certification, training, experience and current clinical competence are documented. Additional privileges may be requested and reviewed on an individual basis.