

Exhibit 44 – Confidential Exhibit

Confidential Exhibit 44 – Credentialing

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Exhibit 44B

KENT HOSPITAL

CREDENTIALS POLICY

Reviewed and Approved by Medical Executive Committee

February 20, 2020

Reviewed and Approved by the Medical Staff

July 6, 2020

Reviewed and Approved by the Board of Directors

July 23, 2020

Horty, Springer & Mattern, P.C.

CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (1) “ADVANCED PRACTICE CLINICIAN STAFF” consists of health care professionals who are authorized by law and by the Hospital to provide patient care services. A list of the categories of professionals who are members of the Advanced Practice Clinician Staff is included at Appendix A.
- (2) “ADVANCED PRACTICE REGISTERED NURSE” means a nurse with post-graduate education in nursing, including certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and certified clinical nurse specialists, who has completed an education program that is accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education and/or the Council for Higher Education Accreditation and who is certified by the American Board of Nursing Specialties or the National Commission for Certifying Agencies.
- (3) “AFFILIATED ENTITY” means any entity that is directly or indirectly controlled by, or is under common control along with, the Hospital.
- (4) “APPLICANT” means an individual who has submitted an application for initial appointment or reappointment to the Medical Staff or has submitted an application for clinical privileges.
- (5) “BOARD” means the Board of Directors of the Hospital Corporation, which has the overall responsibility for the Hospital, or its designated committee.
- (6) “BOARD CERTIFICATION” is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, or the Royal College of Physicians and Surgeons of Canada, as applicable. For an advanced practice clinician, the certifying body approved by the Hospital will be included in the delineation of clinical privileges.
- (7) “CHIEF MEDICAL OFFICER” means the individual appointed by the President of the Hospital and ratified by the Board to provide overall administrative management of physician services and to serve as liaison between the Medical Staff and the Hospital Administration.

- (8) "CHIROPRACTOR" means an individual who has successfully graduated from a school or college of chiropractic medicine accredited by the Council on Chiropractic Education.
- (9) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.
- (10) "CONSULTING STAFF" means the Consulting Staff as set forth in the Medical Staff Bylaws.
- (11) "CORE PRIVILEGES" or "CORE" means a defined grouping of clinical privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.
- (12) "CREDENTIALS COMMITTEE" means the Hospital's Medical Staff Credentials Committee as set forth in the Medical Staff Organizational Manual.
- (13) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.
- (14) "DAYS" means calendar days.
- (15) "DEPARTMENT CHIEF" means the chief of the clinical department and, when appropriate, the division chief.
- (16) "DENTIST" means a doctor of dental surgery or doctor of dental medicine.
- (17) "*EX OFFICIO*" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
- (18) "HOSPITAL" means Kent County Memorial Hospital doing business as Kent Hospital.
- (19) "HOSPITAL ADMINISTRATION" means the President of the Hospital, or the Chief Medical Officer, or his or her designee, including the administrator on call.
- (20) "INVESTIGATION" means the process initiated by a resolution of the Medical Executive Committee, or the Board, to evaluate the validity of questions or concerns pertaining to the clinical competence or professional conduct about a member. An investigation is concluded after final action has been taken in accordance with the process as set forth in this Policy. A routine or general review of cases or any evaluation prior to the commencement of an investigation

by the Medical Executive Committee, or the Board, is not considered an investigation.

- (21) "LEADERSHIP COUNCIL" means Leadership Council as set forth in the Medical Staff Organizational Manual.
- (22) "MEDICAL EXECUTIVE COMMITTEE" means the Medical Executive Committee of the Medical Staff as set forth in the Medical Staff Bylaws.
- (23) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, podiatrists, and advanced practice clinicians who have been appointed to the Medical Staff by the Board.
- (24) "MEDICAL STAFF GOVERNANCE DOCUMENTS" means the Medical Staff Bylaws, Credentials Policy, Organization Manual, Medical Staff Rules and Regulations, and Medical Staff Policies and Procedures.
- (25) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chief, division chief, or committee chairperson.
- (26) "MEDICAL STAFF POLICIES AND PROCEDURES" means those policies and procedures that have been approved by the Medical Executive Committee and the Board. Medical staff policies and procedures will be maintained by the Medical Staff Office.
- (27) "MEMBER" means a physician, dentist, oral surgeon, advanced practice clinician, or health care professional who has been granted appointment to the Medical Staff by the Board.
- (28) "NOTICE" means written communication by regular hand delivery, U.S. mail, e-mail, facsimile, or Hospital mail.
- (29) "ORAL SURGEON" means a doctor of dental surgery.
- (30) "PATIENT CONTACTS" means any admission, consultation, procedure, physical response to emergency call, evaluation, treatment or service performed in the Hospital or its Licensed Facilities. Patient contacts do not include referrals for diagnostic or laboratory tests or x-rays.
- (31) "PHYSICIAN" includes both doctors of medicine and doctors of osteopathy.
- (32) "PHYSICIAN ASSISTANT" means an individual who has successfully completed a physician assistant training program that is accredited by the AMA Committee on Allied Health Education and Accreditation and by the American Association of Physician Assistants, and who is certified by the National Commission on Certification of Physician Assistants.

- (33) “PODIATRIST” means a doctor of podiatric medicine.
- (34) “PRESIDENT OF THE HOSPITAL” means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (35) “PROFESSIONAL PRACTICE EVALUATION” refers to the Hospital’s routine and ongoing peer review, performance improvement, and professional practice evaluation processes. These processes include, but are not limited to, the review and assessment of an individual’s clinical performance, professionalism, and ability to exercise clinical privileges safely and competently.
- (36) “PROFESSIONAL REVIEW ACTION” and “PROFESSIONAL REVIEW ACTIVITY” have the meanings defined in the Health Care Quality Improvement Act of 1986.
- (37) “PSYCHOLOGIST” means an individual with a doctoral degree in psychology.
- (38) “RESTRICTION” means a professional review action based on clinical competence or professional conduct which results in the inability of an individual to exercise his or her own independent judgment for a period longer than 30 days (for example, a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised, or other requirement that another physician must agree before privileges can be exercised). Conditions built into a performance improvement plan are not considered a restriction.
- (39) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (40) “SPECIAL PRIVILEGES” means clinical privileges that fall outside of the core privileges for a given specialty, which require additional education, training, or experience beyond that required for core privileges in order to demonstrate competence.
- (41) “SUPERVISING PHYSICIAN” means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with an advanced practice clinician.
- (42) “SUPERVISION” means the supervision of (or collaboration with) an advanced practice clinician by a supervising physician, that may or may not require the actual presence of the supervising physician, but that does require, at a minimum, that the supervising physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each advanced practice clinician is credentialed and will be consistent with any applicable written supervision or collaboration agreement.

- (43) "SYSTEM" means Care New England Health System or any of its partner organizations.
- (44) "TELEMEDICINE" is the provision of clinical services to patients by practitioners from a distance via electronic communications. Physicians who are granted telemedicine privileges will be eligible for appointment to the Consulting Staff.
- (45) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B. TIME LIMITS

Time limits referred to in this Policy and related bylaws, medical staff policies and procedures and manuals are advisory only and are not mandatory, unless it is expressly stated.

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a Medical Staff Leader, or a Medical Staff committee, or a member of Hospital Administration, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees. Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff governance documents and policies and procedures.
- (2) When a member of the Medical Staff is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.D.1. Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

- (a) to another authorized individual or body and for the purpose of conducting professional review activity;
- (b) as authorized by a policy; or

- (c) as authorized by the President of the Hospital or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality is encouraged to inform the President of the Hospital, the Chief Medical Officer, or the President of the Medical Staff.

1.D.2. Peer Review Protection:

All professional review and peer review activity will be performed by peer review committees. These committees include, but are not limited to:

- (a) all standing and ad hoc Medical Staff and Hospital committees;
- (b) all departments, divisions, and service lines;
- (c) hearing and appellate review panels;
- (d) the Board and its committees; and
- (e) any individual or body acting for or on behalf of a peer review committee, Medical Staff Leaders, and experts or consultants retained to assist in professional review activity.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law and are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq.

1.E. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, all Medical Staff Leaders, Medical Staff committees, members, and authorized representatives when engaged in those capacities, in accordance with applicable laws and the Hospital's Bylaws.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

- (a) To be eligible to apply for initial appointment, reappointment, and clinical privileges, an individual must demonstrate satisfaction of all of the following threshold eligibility criteria, as applicable:
 - (1) have a current, unrestricted license to practice in Rhode Island that is not subject to any restrictions, probationary terms, or conditions;
 - (2) not currently be under investigation by any state licensing agency and have never had a license to practice denied, revoked, restricted or suspended by a state licensing agency;
 - (3) have a current, unrestricted DEA registration and the appropriate state controlled substance license, and have never had a DEA registration or state controlled substance license denied, revoked, restricted or suspended;
 - (4) be located (office and residence) close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;
 - (5) have current, valid professional liability insurance coverage in amounts satisfactory to the Hospital;
 - (6) have current, government-issued photographic identification which verifies the individual's identity;
 - (7) have successfully completed the following professional training requirements:
 - (i) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges;
 - (ii) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;

- (iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or
 - (iv) for advanced practice clinicians, have satisfied the applicable training requirements as established by the Hospital;
- (8) if granted clinical privileges, satisfy the following board certification requirements:
- (i) are certified in their primary area of practice at the Hospital by an approved board as defined in this Policy; or
 - (ii) are within six years of completion of residency or fellowship training and achieve board certification in their primary area of practice within six years from the date of completion of their residency or fellowship training; and
 - (iii) maintain board certification in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so;
- (9) satisfy the following professional practice and experience requirements:
- (i) demonstrate recent clinical activity in their primary area of practice during at least 18 of the last 24 months;
 - (ii) have never had staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including the Hospital, or health plan for reasons related to clinical competence or professional conduct;
 - (iii) have never resigned staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including the Hospital;
 - (iv) have never had an application for appointment or clinical privileges not processed, nor had appointment or privileges automatically relinquished, at the Hospital or any of its affiliated entities, due to an omission or misrepresentation;
 - (v) have never been terminated from a post-graduate training program (residency or fellowship for physicians or a similarly equivalent program for other categories of practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

- (vi) not currently be under any criminal investigation or indictment and have not, within the last ten years, been convicted of, or entered a plea of guilty or no contest to, any felony, or to any misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or other federal, state governmental or private third-party payer fraud; (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; (vii) child or elder abuse; (viii) the practitioner-patient relationship; and
 - (vii) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (10) if granted clinical privileges, satisfy the following Hospital practice requirements:
- (i) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;
 - (ii) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;
 - (iii) have an appropriate coverage arrangement, as determined by the Credentials Committee and the Medical Executive Committee, with other members of the Medical Staff for those times when the individual will be unavailable;
 - (iv) document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;
 - (v) agree to fulfill all responsibilities regarding emergency call for their specialty;
 - (vi) document compliance with health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures) (telemedicine practitioners are exempt from this criterion); and
- (11) if seeking to practice as an advanced practice clinician, must have a written agreement with a Supervising/Collaborating Physician, which agreement must meet all applicable requirements of Rhode Island law, as applicable, and Hospital policy.

- (b) In order to be eligible for continued appointment and privileges, members must demonstrate satisfaction of the above threshold eligibility criteria, as applicable, on an ongoing basis.

2.A.2. Process for Waiver of Threshold Eligibility Criteria:

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria will be notified and may request a waiver as outlined below. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver will first be reviewed by the department chief who will make a recommendation to the Credentials Committee. In reviewing the request for a waiver, the department chief and Credentials Committee may consider the specific qualifications of the applicant, the best interests of the Hospital and the communities it serves, the application form, and other information supplied by the applicant.
- (c) The Credentials Committee will forward its recommendation, including its reasons, to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific reasons for the recommendation.
- (d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific reasons for the recommendation.
- (e) The Board's determination regarding whether to grant a waiver is final.
- (f) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent reappointment cycles.
- (g) A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.
- (h) A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent.

2.A.3. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. Burden of Providing Information:

- (a) All individuals and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts. This includes information that may be needed to assist in an appropriate assessment of qualifications for appointment, reappointment, and clinical privileges, such as information from other hospitals, the individual's office practice, insurers or managed care organizations, and/or confidential evaluation forms.
- (b) Individuals have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application are accurate and complete.
- (c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 60 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

- (d) Applicants are responsible for providing a complete application, including adequate responses from references and all information requested from third parties for a proper evaluation. An incomplete application will not be processed.
- (e) Applicants and members are responsible for notifying the Medical Staff Office of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but is not limited to:
 - (1) any information on the application form;
 - (2) any threshold eligibility criteria for appointment or clinical privileges;
 - (3) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization or state controlled substance license;
 - (4) changes in professional liability insurance coverage;
 - (5) the filing of a professional liability lawsuit against the practitioner;
 - (6) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;
 - (7) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same; and
 - (8) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health).

2.A.5. No Entitlement to Appointment:

No one is entitled to receive an application, be appointed, reappointed or be granted or exercise particular clinical privileges merely because he or she:

- (a) is employed by the Hospital, or its subsidiaries, or has a contract with the Hospital;
- (b) is or is not a member or employee of any particular physician group;
- (c) is licensed to practice a profession in this or any other state;

- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, staff appointment or privileges at any hospital or health care facility;
- (f) resides in the geographic service area of the Hospital; or
- (g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.6. Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of age, gender, sexual orientation, gender identification, race, creed, color, national origin, or religion.

2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT,
& CLINICAL PRIVILEGES

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment or clinical privileges and as a condition of ongoing appointment and maintenance of clinical privileges, every individual specifically agrees to the following:

- (a) to provide continuous and timely care;
- (b) to abide by the medical staff policies and procedures and the policies of the Hospital, and any revisions or amendments thereto;
- (c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;
- (d) to provide emergency call coverage, consultations, and care for unassigned patients;
- (e) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
- (f) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the Medical Executive Committee or document the clinical reasons for variance;
- (g) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

- (h) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood, urine or hair testing) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy or other Medical Staff policy;
- (i) to obtain, when requested, an evaluation of current clinical competence by a consultant or program selected by the Hospital;
- (j) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care;
- (k) to use the Hospital sufficiently to allow continuing assessment of current competence;
- (l) to seek consultation whenever necessary;
- (m) to complete in a timely manner all medical and other required records;
- (n) to utilize the Hospital's electronic medical record system;
- (o) to satisfy continuing medical education requirements;
- (p) to promptly pay any applicable dues, assessments, or fines;
- (q) to meet with Medical Staff Leaders and/or Hospital Administration, provide information regarding professional qualifications, and participate in collegial efforts as may be requested;
- (r) to maintain and monitor a current e-mail address with the Medical Staff Office, which will be the primary mechanism used to communicate information to members of the Medical Staff;
- (s) to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);
- (t) to cooperate with all care management activities;
- (u) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital; and
- (v) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies.

2.B.2. Immunity and Authorization to Obtain and Release Information:(a) Conditions Prerequisite to Application and Consideration:

As a condition of having a request for application considered or applying for appointment, reappointment, or clinical privileges, every individual accepts the terms set forth in this Section.

(b) Scope of Conditions:

The terms set forth in this Section:

- (1) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment, or clinical privileges are granted;
- (2) apply throughout the credentialing process and the term of any appointment, reappointment, or clinical privileges; and
- (3) survive for all time, even if appointment, reappointment, or clinical privileges is denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if the individual no longer maintains appointment, or clinical privileges at the Hospital.

(c) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which will include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, or clinical privileges, or the individual's qualifications for the same, including, but not limited to:

- (1) information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without accommodation;
- (2) any matter addressed on the application form or in the Medical Staff Bylaws, Credentials Policy, and other Hospital or medical staff policies and rules and regulations;
- (3) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and
- (4) any references received or given about the individual.

(d) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(e) Authorization to Share Information Among Affiliated Entities:

The individual authorizes Affiliated Entities to share with one another information pertaining to the individual's clinical competence, professional conduct, and health. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.

(f) Authorization to Obtain Information from Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

(g) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(h) Access to Information by Individuals:

- (1) Upon request, applicants will be informed of the status of their applications for appointment, or clinical privileges.
- (2) Except during the hearing and appeal processes, which are governed by Article 7 of this Policy, an individual may review information obtained or maintained by the Hospital only upon request and only if the identity of the individual who provided the information will not be revealed.
- (3) If an individual disputes any information obtained or maintained by the Hospital, the individual may submit, in writing, a correction or clarification of the relevant information which will be maintained in the individual's file.

(i) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(j) Immunity:

- (1) To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, or Board, and any third party who provides information.
- (2) This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or Rhode Island law.

(k) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, or Board, and any third party who provides information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees, and expert witness fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. APPLICATION

3.A.1. Application Form:

- (a) Application forms for appointment, reappointment, and clinical privileges will be approved by the Board, upon recommendation by the Credentials Committee and the Medical Executive Committee.
- (b) The applications for initial appointment, reappointment, and clinical privileges existing now, and as may be revised, are incorporated by reference and made a part of this Policy.
- (c) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.
- (d) In addition to other information, the applications seek the following:
 - (1) information as to whether the applicant's Medical Staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;
 - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Medical Executive Committee, or the Board may request;
 - (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

- (5) a copy of a government-issued photo identification.

3.A.2. Misstatements and Omissions:

- (a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The President of the Medical Staff and Chief Medical Officer will review the response and determine whether the application should be processed further.
- (b) If appointment has been granted prior to the discovery of a misstatement or omission, the individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The individual will also have an opportunity to meet with the Leadership Council to explain the misstatement or omission. The Leadership Council will review the response and determine whether appointment and privileges should be deemed to be automatically resigned pursuant to this Policy.
- (c) No action taken pursuant to this Section will entitle the applicant or member to a hearing or appeal.

3.B. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.B.1. Application Process:

- (a) Prospective applicants will be sent the application form and a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges.
- (b) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt. The application must be accompanied by the application fee.
- (c) Applications may be provided to residents and fellows who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.B.2. Initial Review of Application:

- (a) As a preliminary step, the application will be reviewed by the Chief Medical Officer to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not

entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

- (b) The Medical Staff Office will oversee the process of gathering and verifying relevant information and confirming that all references and other information deemed pertinent have been received.

3.B.3. Steps to Be Followed for Initial Applicants:

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chief at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank will be queried, the Office of Inspector General's List of Excluded Individuals/Entities will be checked, and a criminal background check will be obtained.
- (b) Interview(s) with the applicant are encouraged, especially for applicants seeking clinical privileges. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by any of the following: the department chief, the Credentials Committee, two or more members of the Credentials Committee, the Medical Executive Committee, the President of the Medical Staff, the Chief Medical Officer, or the President of the Hospital.
- (c) The Medical Staff Office will transmit the complete application and all supporting materials to the chief of each department in which the applicant seeks clinical privileges (and, where applicable, to the division chief).

3.B.4. Department Chief and Chief Nursing Officer Procedure:

- (a) The department chief or division chief will prepare a written report regarding whether the applicant has satisfied the qualifications for appointment and the clinical privileges requested. The report will be on a form provided by the Medical Staff Office.
- (b) The Chief Nursing Officer will also review and report on the applications for advanced practice nurses.

3.B.5. Credentials Committee Procedure:

- (a) The Credentials Committee will consider the report prepared by the division chief, department chief(s) and, if appropriate, the Chief Nursing Officer, and will make a recommendation.

- (b) The Credentials Committee may rely on the expertise of the division chief and department chief(s), or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee. Failure of an applicant to undergo a fitness for practice evaluation within a reasonable time after being requested to do so in writing by the Credentials Committee will be considered a voluntary withdrawal of the application and all processing of the application shall cease.
- (d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions.

3.B.6. Medical Executive Committee Recommendation:

- (a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the Medical Executive Committee will:
 - (1) adopt the report and recommendation of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration of specific questions; or
 - (3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.
- (b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board.
- (c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the President of the Hospital, who will promptly send special notice to the applicant. The President of the Hospital will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.B.7. Board Action:

- (a) The Care of New England Credentials Oversight Committee may take action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:
- (1) a current or previously successful challenge to any license or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint will be effective immediately and will be forwarded to the Board for consideration at its next meeting.

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
- (1) grant appointment and clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or Medical Executive Committee or to another source for additional research or information; or
 - (3) modify the recommendation.
- (c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chairperson of the Credentials Committee and the chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable, the President of the Hospital will promptly send special notice that the applicant is entitled to request a hearing.
- (d) A decision by the Board to grant appointment will be for a period not to exceed two years.
- (e) Any final decision by the Board to grant, deny, modify, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.B.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Individuals may only exercise those clinical privileges that have been granted by the Board, subject to the terms of this Policy.
- (b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived and the wavier process outlined in Article 2 will be followed.
- (c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract. Similarly, requests for clinical privileges will not be processed if the Hospital has determined not to accept an application in the specialty.
- (d) Recommendations for clinical privileges will be based on consideration of the following:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of coverage in case of the applicant's illness or unavailability;
 - (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;

- (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data, when available;
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions; and
 - (13) the Hospital's need, available resources, and personnel.
- (e) An applicant has the burden of establishing qualifications and current competence for clinical privileges requested.
 - (f) The report of the relevant department chief, division chief, and the Chief Nursing Officer, as applicable, will be processed as a part of the application for privileges. Clinical privileges will be granted for a period not to exceed two years.
 - (g) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

4.A.2. Requests for Limited Privileges Within a Core or Specialty:

- (a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)
- (b) In appropriate circumstances, the Board may grant limited clinical privileges within a core or specialty as requested by an individual on the application. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a basis for the request, and include evidence that the individual does **not** provide the patient care services in any health care facility in that area.
- (c) A request for limited clinical privileges will be reviewed by the relevant department chief, Credentials Committee, Medical Executive Committee, and Board.

- (d) The following factors, among others, may be considered in deciding whether to grant limited privileges within the core or specialty:
- (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;
 - (2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Labor Act;
 - (3) the expectations of members who rely on the specialty;
 - (4) fairness to the individual requesting the waiver;
 - (5) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and
 - (6) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.
- (e) No one is entitled to be granted limited clinical privileges within a core or specialty, and denial of such a request does not trigger a right to a hearing or appeal.

4.A.3. Resignation of Limited Clinical Privileges:

A request to resign limited clinical privileges, whether or not part of the core, must provide a basis for the request. All such requests will be processed in the same manner as a request for limited clinical privileges, as described above.

4.A.4. Resignation of Appointment and Clinical Privileges:

A request to resign all clinical privileges should specify the desired date of resignation, at least 30 days from the date of the request, and provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the President of the Medical Staff, the President of the Hospital will act on the request.

4.A.5. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that

the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the Chief Medical Officer addressing the following:
 - (1) appropriate education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;
 - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
 - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
 - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions;
 - (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure;
 - (7) whether the new procedure is investigational and, if so, whether there has been IRB approval; and
 - (8) whether the new procedure has received any regulatory approval (e.g., FDA) and whether it has a favorable safety profile.
- (c) The Chief Medical Officer will review this report and consult with the department chief and the Credentials Committee (either of which may conduct additional research as may be necessary) and will make a preliminary determination as to whether the new procedure should be offered at the Hospital.
- (d) If the preliminary determination is favorable, the Credentials Committee will consider whether the request constitutes a “new procedure” or if it is an extension of an existing privilege. If it is a “new procedure,” the Credentials Committee will then develop threshold criteria. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:
 - (1) the appropriate education, training, and experience necessary to perform the procedure or service;

- (2) the clinical indications for when the procedure or service is appropriate;
 - (3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and
 - (4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.
- (e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.6. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that previously, at the Hospital, have been exercised only by members in another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.
- (b) As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.
- (c) The Credentials Committee may conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If it recommends that individuals from different specialties be permitted to request clinical privileges, the Credentials Committee may develop recommendations regarding:
 - (1) the appropriate education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate to be performed by individuals in a different clinical specialty;

- (3) the manner of addressing the most common complications that arise, which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
 - (5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.7. Physicians and Other Practitioners in Training:

Physicians and other practitioners in training, including but not limited to medical students, advanced practice nurses, and physician assistants in training programs ("Trainees"), will not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each Trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols. The applicable training program will be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.8. Focused Professional Practice Evaluation for Initial Privileges:

- (a) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused professional practice evaluation by the department chief or by a physician(s) designated by the Credentials Committee.
- (b) This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the Credentials Committee.
- (c) The new member's appointment and privileges will expire if the member fails to fulfill the clinical activity requirements within the time frame recommended by

the Credentials Committee, including any extensions. In such case, the individual may not reapply for initial appointment or privileges for two years.

- (d) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame recommended by the Credentials Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for two years.
- (e) When, based upon information obtained through the focused professional practice evaluation process, a recommendation is made to terminate, revoke, or restrict clinical privileges for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges for Initial Applicants:

- (a) Temporary privileges may be granted by the Chief Medical Officer, in consultation with the President of the Medical Staff, to applicants for initial appointment whose complete application, following a favorable recommendation of the Credentials Committee, is pending review by the Medical Executive Committee and Board.
- (b) Prior to granting temporary privileges to applicants, at a minimum, the following information will be verified: (1) current licensure; (2) relevant training and experience; (3) current competence; (4) current professional liability coverage acceptable to the Hospital; (5) an ability to perform the clinical privileges requested; (6) result from a query to the National Practitioner Data Bank; (7) result from a query to the Office of Inspector General's List of Excluded Individuals/Entities; and (8) criminal background check. Additionally, an applicant must demonstrate there have been no current or previously successful challenges to licensure or registration and there have not have been any involuntary limitation, restriction, reduction, denial, loss or termination of appointment or clinical privileges at another health care facility.
- (c) All information required of initial applicants will be verified prior to the granting of any temporary clinical privileges.
- (d) The grant of temporary clinical privileges to an initial applicant will not exceed 120 days.

4.B.2. Temporary Clinical Privileges for an Important Patient Care Need:

- (a) Temporary privileges may be granted by the Chief Medical Officer, in consultation with the President of the Medical Staff, to non-applicants, when there is an important patient care, treatment, or service need, including the following:

- (1) the care of a specific patient; (2) when necessary to prevent a lack of services in a needed specialty area; (3) proctoring; or (4) when serving as a locum tenens for a member of the Medical Staff.
- (b) Prior to granting temporary privileges to non-applicants, at a minimum, the following information will be verified: (1) current licensure; (2) relevant training and experience; (3) current competence; (4) current professional liability coverage acceptable to the Hospital; (5) result from a query to the National Practitioner Data Bank; and (6) result from a query to the Office of Inspector General's List of Excluded Individuals/Entities. A criminal background check may also be performed.
- (c) Prior to any temporary clinical privileges being granted, the individual must agree in writing to be bound by the medical staff governance documents and Hospital policies, and any revisions or amendments thereto.
- (d) For non-applicants, who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:
- (1) the individual must notify the Medical Staff Office at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and
 - (2) the individual must inform the Medical Staff Office of any change that has occurred to the information provided on the application form for locum tenens privileges.

4.B.3. General Provisions Relating to Temporary Clinical Privileges:

- (a) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the President of the Hospital at any time, after consulting with the President of the Medical Staff, the chairperson of the Credentials Committee or the department chief.
- (b) The department chief or the President of the Medical Staff will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

4.C. TELEMEDICINE PRIVILEGES

4.C.1. Processing Requests for Telemedicine Privileges:

- (a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.
- (b) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.
- (c) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the Chief Medical Officer, in consultation with the President of the Medical Staff:
 - (1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.
 - (2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity is accredited by the Joint Commission, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:
 - (i) confirmation that the practitioner is licensed in the state where the Hospital is located;
 - (ii) a current list of privileges granted to the practitioner;
 - (iii) a signed attestation by the chief medical officer or the president of the medical staff that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;
 - (iv) a signed attestation by the chief medical officer or the president of the medical staff that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

- (v) any other attestations or information required by the agreement or requested by the Hospital.

Prior to granting telemedicine privileges, the National Practitioner Data Bank will be queried and the Office of Inspector General's List of Excluded Individuals/Entities will be checked.

This information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this section, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

- (d) Telemedicine privileges, if granted, will be for a period of not more than two years.

4.C.2. Review of Telemedicine Privileges:

- (a) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.
- (b) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

4.D. EMERGENCY AND DISASTER PRIVILEGES

4.D.1. Emergency Situations:

- (a) For the purpose of this Section, an "emergency" is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.
- (b) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (c) When the emergency situation no longer exists, the patient will be assigned by the department chief or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D.2. Disaster Privileges:

- (a) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President of the Hospital or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners (“volunteers”). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (b) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (1) A volunteer’s identity may be verified through a valid government-issued photo identification (i.e., driver’s license or passport).
 - (2) A volunteer’s license may be verified in any of the following ways: (1) current hospital picture ID card that clearly identifies the individual’s professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual’s ability to act as a volunteer during a disaster.
- (c) Primary source verification of a volunteer’s license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
- (d) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer’s demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- (e) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.
- (f) Disaster privileges are intended to be granted for a limited period of time to help address an immediate patient care need in the Hospital. The grant of disaster

privileges is a courtesy which may be lifted at any time by the President of the Hospital or the President of the Medical Staff.

4.E. CONTRACTS FOR SERVICES AND EMPLOYED MEDICAL STAFF MEMBERS

- (1) From time to time, the Hospital may enter into contracts with practitioners or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.
- (2) To the extent that:
 - (a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or
 - (b) the Board by resolution limits the practitioners who may exercise clinical privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioners except those authorized by or pursuant to the contract or arrangement may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners so authorized are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

- (3) If the Board determines to proceed with an exclusive contract or Board resolution, and if that determination would have the effect of preventing an existing member of the Medical Staff from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and hearing procedures:
 - (a) The affected member will be given at least 60 days' advance notice of the exclusive contract or Board resolution. The notice will inform the member of the right to request a hearing as outlined in this Section prior to the contract being signed by the Hospital or the Board resolution becoming effective.
 - (b) The affected member must request the hearing within 14 days of receiving the notice, and the hearing must then be commenced and concluded within 30 days of the member's request unless the individual and the Board agree upon a different time frame. A report and recommendation must be prepared by the hearing committee within this 30-day period and copies sent to the affected member, the Board, and the Medical Executive Committee.

- (c) The affected member may be represented by counsel at the hearing, but must notify the Hospital of that fact at the time that the hearing is requested. If the affected member chooses to be accompanied by counsel, the Board may also be represented by legal counsel at the hearing.
 - (d) The hearing will be held before a committee appointed by the Board, which will include representatives from the Medical Executive Committee. At the hearing, the affected member will be entitled to present any information and documentation that he or she deems relevant to the Board's decision to enter into the exclusive contract or enact the resolution, as well as to present witnesses in support of his or her position.
 - (e) Following receipt of the hearing committee's report and recommendation, the Board will make a final decision in the matter. If the Board confirms its initial determination to enter into the exclusive contract or enact the resolution, the affected member will be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or resolution and continues for as long as the contract or resolution is in effect.
 - (f) The affected member will only be entitled to any procedural rights outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges. The provisions in Article 7 of this Policy are not applicable to the Board decision to enter into an exclusive contract or enact a resolution even when the effect of such is that a member is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or resolution.
 - (g) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Rhode Island licensure board or to the National Practitioner Data Bank.
- (4) Except as provided in paragraph (1), in the event of any conflict between this Policy and the terms of any contract, the terms of the contract will control. In particular, nothing in this Section will preclude or limit a Medical Staff member's right to waive, in writing, his or her right to request a hearing upon being granted the exclusive right to provide particular services at the Hospital, either individually or as a member of a group. If any exclusive contract is signed by a representative of a group of physicians, any waiver that is contained in the contract shall apply to all members of the group unless stated otherwise in the contract.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will, as applicable, apply to continued appointment and clinical privileges and to reappointment.

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous term of appointment or privileges:

- (a) completed all medical records and be current at the time of reappointment;
- (b) completed all continuing medical education requirements;
- (c) satisfied all Medical Staff responsibilities, including payment of any dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) paid any applicable reappointment processing fee; and
- (f) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application will be considered complete and processed further.

5.B.2. Factors for Evaluation:

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

- (a) compliance with the medical staff governance documents and the policies of the Hospital;

- (b) participation in Medical Staff duties, including committee assignments and emergency call;
- (c) the results of the Hospital's performance improvement activities, including ongoing and focused professional practice evaluation, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
- (d) feedback received from patients and their families, visitors, or staff; and
- (e) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

- (a) Appointment terms will not extend beyond two years.
- (b) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days. Along with the completed application, members must also submit payment for Medical Staff dues and for the reappointment application fee.
- (c) Failure to return a completed application within 30 days will result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. In addition, failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort.
- (d) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (e) The Medical Staff Office will oversee the process of gathering and verifying relevant information. The Medical Staff Office will also be responsible for confirming that all relevant information has been received.

5.C.2. Processing Applications for Reappointment:

- (a) The Medical Staff Office will forward the application to the relevant department chief or division chief and the application for reappointment will be processed in a manner consistent with applications for initial appointment.
- (b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.C.3. Conditional Reappointments:

- (a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's clinical performance, professional conduct, and ongoing qualifications for appointment and privileges.
- (b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.
- (c) Additionally, if questions or concerns are being addressed at reappointment or in the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.C.4. Potential Adverse Recommendation:

- (a) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairperson will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.
- (c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.
- (d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting and no recording (audio or video) of the meeting will be permitted or made.

CONFIDENTIAL

ARTICLE 6

MANAGING QUESTIONS ABOUT MEDICAL STAFF MEMBERS

6.A. INITIAL COLLEGIAL EFFORTS AND PROGRESSIVE STEPS

6.A.1. Options Available to Medical Staff Leaders and Hospital Administration:

- (a) This Policy encourages the use of collegial efforts and progressive steps to address and resolve questions that may be raised about a member's competence, health or behavior.
- (b) Initial collegial efforts include activities such as:
 - (1) informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records); and
 - (2) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms.

These efforts are not required to be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the individual's confidential file.

- (c) Progressive steps include, but are not limited to, the following actions:
 - (1) addressing minor performance issues through an informational letter;
 - (2) sending an educational letter that describes opportunities for improvement and provides specific guidance and suggestions;
 - (3) facilitating a formal collegial intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it;
 - (4) communicating expectations for professionalism and behaviors that promote a culture of safety; and
 - (5) developing a performance improvement plan that can be used to address a concern.

Progressive steps are to be documented and included in a member's confidential file. The written response by the member to any of these progressive steps will also be included in the member's confidential file.

- (d) These collegial efforts and progressive steps are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and protected in accordance with state law.
- (e) Initial collegial efforts and progressive steps are encouraged, but are not mandatory, and are within the discretion of the appropriate Medical Staff Leaders and Hospital Administration. When a question arises, the Medical Staff Leaders and/or Hospital Administration may:
 - (1) address it pursuant to the initial collegial efforts and progressive steps provisions of this Section;
 - (2) refer the matter for review in accordance with the peer review policy, professionalism policy, practitioner health policy, or other relevant policy; or
 - (3) refer it to the Medical Executive Committee for its review and action.
- (f) There will be no recording (audio or video) or transcript made of any meetings that involve initial collegial efforts or progressive steps activities.

6.A.2. No Right to the Presence of Others:

Credentialing and peer review activities, including all activities set forth in this Article, are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article.

6.A.3. No Right to Counsel:

- (a) Members do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital Administration engage in initial collegial efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner. By agreement of the President of the Medical Staff and Chief Medical Officer, an exception may be made to this general rule.
- (b) If the individual refuses to meet without his or her lawyer present, the meeting will be cancelled and it will be reported to the Medical Executive Committee that the individual declined to attend the meeting

6.A.4. Involvement of Supervising Physician in Matters Pertaining to Advanced Practice Clinician:

If any peer review activity pertains to the clinical competence or professional conduct of an advanced practice clinician, the Supervising Physician (if any) will be notified and may be invited to participate.

6.B. OTHER OPTIONS

6.B.1. Mandatory Meeting:

- (a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff Leaders may require the individual to attend a mandatory meeting.
- (b) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.
- (c) Failure of an individual to attend a mandatory meeting may result in an administrative relinquishment of appointment and privileges as set forth below.

6.B.2. Fitness for Practice Evaluation:

- (a) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a comprehensive fitness for practice evaluation which may include a physical, psychological, or cognitive assessment, to determine his or her ability to safely and competently practice.
- (b) A request for a fitness for practice evaluation may be made as follows:
 - (1) of an applicant during the initial appointment or reappointment processes when requested by the Credentials Committee;
 - (2) of a member during an investigation; and
 - (3) of a member seeking reinstatement from a leave of absence.
- (c) A request for an immediate evaluation may also be made when two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.
- (d) The Medical Staff Leaders, Hospital Administration, or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate

releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.

- (e) Failure to obtain the requested evaluation may result in an application being withdrawn or an administrative relinquishment of appointment and privileges as set forth below.

6.B.3. Competency Assessment:

- (a) An individual may be requested to participate in a competency assessment to determine his or her ability to safely and competently practice.
- (b) A request for a competency assessment may be made of a member during the reappointment process, as part of the collegial intervention process, or during an investigation. The request may be made by Medical Staff Leaders, the Credentials Committee, the Medical Executive Committee, an Investigating Committee or the Provider Refinement Committee.
- (c) The Medical Staff Leaders or committee that requests the assessment will:
 - (i) identify the health care professional(s) to perform the assessment; (ii) inform the individual of the time period within which the assessment must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the assessment and to allow the health care professional to discuss and report the results of the assessment to the Medical Staff Leaders or relevant committee.
- (d) Failure to obtain the requested assessment may result in an administrative relinquishment of appointment and privileges as set forth below.

6.C. ADMINISTRATIVE RELINQUISHMENT

- (1) Any of the occurrences described in this Section may constitute grounds for the administrative relinquishment of an individual's appointment and clinical privileges. An administrative relinquishment is considered an administrative action, not an adverse professional review action, and, as such, it generally does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.
- (2) Except as otherwise provided below, an administrative relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual.

6.C.1. Failure to Complete Medical Records:

Failure of an individual to complete medical records, after notification by the medical records department of the delinquency in accordance with applicable policies and rules and regulations, may result in administrative relinquishment of all clinical privileges.

6.C.2. Failure to Satisfy Threshold Eligibility Criteria:

Failure of an individual to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in this Policy will result in administrative relinquishment of appointment and clinical privileges, unless a waiver is granted.

6.C.3. Criminal Activity:

The occurrence of specific criminal actions may, as recommended by the Medical Executive Committee and confirmed by the Chief Medical Officer, result in the administrative relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony or any misdemeanor involving the following may result in an administrative relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; (g) child or elder abuse; or (h) the practitioner-patient relationship

6.C.4. Failure to Provide Information:

- (a) Failure of an individual to notify the President of the Medical Staff or Chief Medical Officer of any change in any information provided on an application for initial appointment or reappointment may, as recommended by the Medical Executive Committee and confirmed by the Chief Medical Officer, result in the administrative relinquishment of appointment and clinical privileges.
- (b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Leadership Council, Credentials Committee, Medical Executive Committee, or any other authorized committee may, as recommended by the Medical Executive Committee and confirmed by the Chief Medical Officer, result in the administrative relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

6.C.5. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given, may, as recommended by the Medical Executive Committee and confirmed by the Chief Medical Officer, result in the administrative relinquishment of appointment and clinical privileges. The relinquishment

will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

6.C.6. Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, may, as recommended by the Medical Executive Committee and confirmed by the Chief Medical Officer, result in the administrative relinquishment of appointment and clinical privileges.

6.C.7. Failure to Comply with Request for Fitness for Practice Evaluation:

- (a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.
- (b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) may, as recommended by the Medical Executive Committee and confirmed by the Chief Medical Officer, result in the administrative relinquishment of appointment and privileges.

6.C.8. Failure to Comply with Request for Competency Assessment:

Failure of a member to undergo a requested competency assessment or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the assessment and to allow the health care professional to report the results of the assessment to the Medical Staff Leaders or relevant committee) may, as recommended by the Medical Executive Committee and confirmed by the Chief Medical Officer, result in the administrative relinquishment of appointment and privileges.

6.C.9. Reinstatement from Administrative Relinquishment and Automatic Resignation:

- (a) If an individual believes that the matter leading to the administrative relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.

- (b) A request for reinstatement from an administrative relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff.
- (c) Requests for reinstatement from an administrative relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (d) below.
- (d) All other requests for reinstatement from an administrative relinquishment will be reviewed by the relevant department chief, the chairperson of the Credentials Committee, the President of the Medical Staff, and the Chief Medical Officer. If these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.
- (e) Failure to resolve a matter leading to an administrative relinquishment within 90 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff.

6.D. ACTIONS OCCURRING AT OTHER HOSPITALS AND FACILITIES
WITHIN THE SYSTEM

- (1) Each hospital and health care facility within the System will share information regarding the implementation or occurrence of any of the following actions with all other hospitals and facilities within the System at which an individual maintains medical staff appointment, clinical privileges, or any other permission to care for patients:
 - (a) a leave of absence;
 - (b) imposition of a precautionary suspension or agreement to modify clinical privileges or to refrain from exercising some or all clinical privileges;
 - (c) a professional review action, including denial, suspension, revocation or termination of appointment or clinical privileges for reasons related to the individual's clinical competence, conduct or health;

- (d) administrative relinquishment of appointment or clinical privileges;
 - (e) any involuntary modification of appointment or clinical privileges; and
 - (f) a performance improvement plan.
- (2) Upon notice that any of the actions set forth above have occurred at, or been implemented by, any hospital or facility within the System, that action will be administratively implemented at the Hospital. Alternatively, a determination may be made that the member no longer satisfies threshold eligibility criteria.
- (3) The administrative implementation of an action at the Hospital may be waived by the Board after consideration of a recommendation from the Medical Executive Committee. The administrative implementation of the action will continue unless a waiver has been granted and the practitioner has been notified in writing. Waivers are within the discretion of the Board and are final. A waiver may be granted only as follows:
- (a) based on a finding that the granting of a waiver will not affect patient safety, quality of care, or hospital operations; and
 - (b) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the hospital or other facility where the action first occurred. The burden is on the practitioner to provide evidence showing that a waiver is appropriate.
- (4) Neither the administrative implementation of any action set forth above at the Hospital, nor the denial of a waiver, will entitle any individual to any procedural rights, formal investigation, hearing, or appeal.

6.E. LEAVES OF ABSENCE

6.E.1. Initiation:

- (a) Individuals who will be away from practice at the Hospital for more than 90 days are expected to notify the Medical Staff Office in writing. When possible, the notice should include the expected beginning and ending dates and the reasons for the leave. The duration of the leave may not exceed one year, except for military service.
- (b) The Chief Medical Officer, in consultation with the President of the Medical Staff and the relevant department chief, will determine whether a request for a leave of absence will be granted. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

- (c) Except for maternity leaves, members must report to the Chief Medical Officer any time they are away from patient care responsibilities for longer than 90 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the Chief Medical Officer, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the member's absence from patient care. The member will be sent special notice that a medical leave has been triggered.
- (d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

6.E.2. Duties of Member on Leave:

During a leave of absence, the member may not exercise any clinical privileges and will be excused from staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) and may not exercise the prerogatives of membership. The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation. An individual must submit proof of professional liability insurance or a claims made tail policy covering the duration of the leave of absence.

6.E.3. Reinstatement:

- (a) Individuals requesting reinstatement must submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will be reviewed by the relevant department chief, the chairperson of the Credentials Committee, the President of the Medical Staff, and the Chief Medical Officer.
- (b) If each of these individuals makes a favorable recommendation on reinstatement, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board. The recommendation for reinstatement from the leave of absence may be subject to specific conditions such as proctoring or monitoring in order to allow for a closer assessment of the individual's competence.
- (c) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested. A request for

reinstatement will be processed in accordance with the Practitioner Health Policy. The Practitioner Health Committee may also require that the individual submit a comprehensive fitness for practice evaluation by a physician(s) satisfactory to it.

- (d) If an individual's current appointment expires during a leave of absence, the individual will be permitted to request reappointment at the same time reinstatement is sought. However, an individual whose appointment expired during a leave may not be reinstated prior to final action on his or her reappointment application.
- (e) Failure to request reinstatement from a leave of absence in a timely manner will be deemed a voluntary resignation of appointment and clinical privileges unless an extension is granted by the Chief Medical Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

6.F. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.F.1. Grounds for Precautionary Suspension or Restriction:

- (a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Hospital, the President of the Medical Staff, the relevant department chief, the Chief Medical Officer, the Medical Executive Committee, or the Board chairperson is authorized to (1) suspend or restrict all or any portion of an individual's clinical privileges or (2) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed.
- (b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension or restriction, reasonable efforts will be made to meet with the individual in question and review the concerns and afford the individual an opportunity to respond.
- (c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.
- (d) A precautionary suspension is effective immediately and will be promptly reported to the President of the Hospital and the President of the Medical Staff. A precautionary suspension will remain in effect unless it is modified by the President of the Hospital or the Board.
- (e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including

the names and medical record numbers of the patient(s) involved (if any). The relevant Supervising Physician will be notified when the affected individual is an advanced practice clinician.

- (f) Upon the imposition of a precautionary suspension, the President of the Medical Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.F.2. Medical Executive Committee Procedure:

- (a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension or restriction, the Medical Executive Committee will review the reasons for the action.
- (b) As part of this review, the individual will be invited to meet with the Medical Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.
- (c) At the meeting, the individual may provide information to the Medical Executive Committee and must respond to questions raised by committee members. The individual may also propose ways, other than precautionary suspension or restriction, to protect patients, employees or others while the matter is being reviewed.
- (d) After considering the reasons for the suspension, and the individual's response, if any, the Medical Executive Committee will recommend whether the precautionary suspension should be continued, modified, or lifted. The Medical Executive Committee may also determine whether to begin an investigation or whether to refer the matter for further review consistent with this or another policy.
- (e) If the Medical Executive Committee recommends that the suspension be continued, it will send the individual written notice of its recommendation, including the basis for it. If the Medical Executive Committee recommends that the suspension be modified, or lifted, this recommendation will be forwarded to the President of the Hospital for final action.
- (f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

6.G. INVESTIGATIONS

6.G.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred to the President of the Medical Staff, the department chief, the chairperson of a standing committee, the Chief Medical Officer, the President of the Hospital, or the chairperson of the Board:
 - (1) clinical competence or clinical practice, including patient care, treatment or management;
 - (2) the safety or proper care being provided to patients;
 - (3) the known or suspected violation of ethical standards, the medical staff governance documents or any policy of the Hospital; or
 - (4) conduct that is considered lower than the standards of the Hospital, undermines the Hospital's culture of safety, or is disruptive to the orderly operation of the Hospital, its Medical, including the inability of the member to work harmoniously with others.
- (b) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, will forward it to the Medical Executive Committee. If the question pertains to an advanced practice clinician, the Supervising Physician may also be notified.
- (c) No action taken pursuant to this Section will constitute an investigation.

6.G.2. Initiation of Investigation:

- (a) The Medical Executive Committee will review the matter in question, may discuss the matter with the individual, and will determine whether to conduct an investigation or direct that the matter be handled pursuant to another policy. An investigation will commence only after a determination by the Medical Executive Committee.
- (b) The Medical Executive Committee will inform the individual that an investigation has begun. The notification shall include:
 - (1) the date the investigation was commenced;
 - (2) the composition of the committee that will be conducting the investigation, if already identified;
 - (3) a statement that the individual will be given an opportunity to meet with the committee conducting the investigation before the investigation concludes; and

- (4) a copy of this Section of the Policy, which outlines the process for investigations.
- (c) Notification may be delayed if, in the judgment of the Medical Executive Committee, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital or the Medical Staff.
- (d) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

6.G.3. Appointment of Investigating Committee:

- (a) Once a determination has been made to begin an investigation, the Medical Executive Committee will decide whether to investigate the matter itself or appoint an individual or committee (“Investigating Committee”) to do so. The Investigating Committee may include individuals not on the Medical Staff. The Investigating Committee will not include any individual who:
 - (1) is in direct economic competition with the individual being investigated;
 - (2) is a relative of the individual being investigated;
 - (3) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
 - (4) actively participated in the matter at any previous level.
- (b) Whenever the questions raised concern the clinical competence of the individual under review, the Investigating Committee will include a peer of the individual (e.g., physician, dentist, podiatrist, advanced practice nurse, or physician assistant).

6.G.4. Investigative Procedures:

- (a) The Investigating Committee has the authority to:
 - (1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;
 - (2) conduct interviews and prepare a summary of each interview, which each interviewee will be asked to review, revise, and sign;
 - (3) use external review; or

- (4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.
- (b) If a decision is made to obtain an external review, the individual under investigation will be notified of that decision and the nature of the external review. Upon completion of the external review, the individual will be provided a copy of the reviewer's report.
- (c) The individual will have an opportunity to meet with the Investigating Committee before it prepares its report. Prior to this meeting, the individual will be informed of the questions being investigated. The Investigating Committee may also ask the individual to provide written responses to specific questions related to the investigation.
- (d) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation or that have been identified by the investigating committee during its review. A summary of the interview with the individual will be made and will be included with the Investigating Committee's report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report. The individual may review the interview summary and recommend suggested changes.
- (e) This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.
- (f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 45 days, provided that an external review is not necessary. When an external review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

6.G.5. Report of Investigating Committee:

- (a) At the conclusion of the investigation, the Investigating Committee will prepare a report. The report will include a summary of the investigation process, including a list of documents that were reviewed and individuals who were interviewed, along with witness summaries that were prepared. The report will also include specific findings and conclusions regarding the concerns that were under review and the recommendations of the Investigating Committee.

- (b) The report of the Investigating Committee will be forwarded to the Medical Executive Committee.

6.G.6. Recommendation:

- (a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Medical Executive Committee may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) require monitoring, proctoring or consultation;
 - (5) require additional training or education;
 - (6) recommend reduction or restriction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a specific period of time or until specified conditions have been met;
 - (8) recommend revocation of appointment or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Medical Executive Committee that does not entitle the individual to request a hearing, will be forwarded to the Board for review and action.
- (c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the President of the Hospital, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.
- (d) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the President of the Hospital will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

6.H. DISCIPLINARY ACTIONS TAKEN BY OTHER HOSPITALS

- (1) The President of the Hospital will notify the President of the Medical Staff upon receipt of information from the Board of Medical Licensure and Discipline or another hospital that the appointment or privileges of any member have been suspended, revoked, or limited. As soon as possible after receipt of this information, and no later than 30 days, the President of the Medical Staff will initiate a preliminary inquiry.
- (2) The President of the Medical Staff, in conjunction with the President of the Hospital, will determine whether the member fails to satisfy the threshold criteria set forth in this Policy. Any failure to satisfy threshold criteria will result in administrative relinquishment of appointment and clinical privileges.
- (3) If the member continues to satisfy threshold criteria, the matter will be referred to the Medical Executive Committee for consideration and action. The Medical Executive Committee may determine to (a) adopt the factual findings of, and the actions taken by, the other hospital or (b) commence an investigation as set forth above.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Hearing Rights:

The hearing and appeal process outlined in Sections 7.A through 7.F of this Policy apply to the following:

- (a) an applicant for appointment to the Medical Staff; and
- (b) a member of the Medical Staff.

7.A.2. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:
 - (1) denial of initial appointment;
 - (2) denial of reappointment;
 - (3) revocation of appointment;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges for more than 14 days (other than precautionary suspension);
 - (7) restriction of clinical privileges for more than 30 days, including a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or
 - (8) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.
- (b) No other recommendation or action will entitle the individual to a hearing.
- (c) If the Board makes any of these determinations, without an adverse recommendation by the Medical Executive Committee, an individual would be

entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "Medical Executive Committee" will be interpreted as a reference to the "Board."

7.A.3. Actions Not Grounds for Hearing:

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written explanation regarding these actions which will be included in his or her file:

- (a) determination that an individual is ineligible for appointment or clinical privileges and that the individual's application will not be processed because he or she fails to meet threshold eligibility criteria;
- (b) determination that an individual is ineligible to request appointment or privileges, or to continue appointment or the exercise of privileges because a specialty is closed under a staff development plan or is covered by an exclusive contract;
- (c) determination that an application will not be processed because it is incomplete or untimely;
- (d) determination that an application will not be processed due to a misstatement or omission;
- (e) expiration of appointment and clinical privileges due to a failure to timely submit an application for reappointment;
- (f) change in assigned staff category or a determination that an individual is not eligible for appointment to a specific staff category;
- (g) issuance of a letter of guidance, counsel, warning, or reprimand;
- (h) imposition of conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult, but need not get prior approval for the treatment);
- (i) imposition of a requirement for additional training or continuing education;
- (j) acceptance of a performance improvement plan;
- (k) a requirement that an individual complete a fitness for practice evaluation;
- (l) the grant of conditional appointment or reappointment or the grant of appointment or reappointment for a period of less than two years;

- (m) imposition of a precautionary suspension;
- (n) administrative relinquishment of appointment or privileges;
- (o) denial of a request for a leave of absence or for an extension of a leave;
- (p) activation of automatic medical leave of absence;
- (q) removal from the on-call roster or any other reading or rotational panel;
- (r) decision not to grant, or the withdrawal of, temporary privileges;
- (s) requirement to appear for a special meeting; and
- (t) termination of any contract with or employment by the Hospital.

7.A.4. Notice of Recommendation:

The President of the Hospital will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.A.5. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request must be in writing, to the President of the Hospital, and must include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.A.6. Notice of Hearing and Statement of Reasons:

- (a) The President of the Hospital will schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

- (3) the names of the Hearing Panel members and Presiding Officer, if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and respond with additional information.
- (b) The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The President of the Hospital, after consulting with the President of the Medical Staff and the Chief Medical Officer, will appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson.
- (2) The Hearing Panel may include any combination of:
 - (i) member(s) of the Medical Staff;
 - (ii) physicians and other practitioners not connected with the Hospital (i.e., practitioners not on the Medical Staff); or
 - (iii) layperson(s) who may, or may not, be connected with the Hospital.
- (3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.
- (4) Employment by, or other contractual arrangement with, the Hospital or an affiliated entity will not preclude an individual from serving on the Panel.
- (5) The Hearing Panel will not include any individual who:
 - (i) is in direct economic competition with the individual requesting the hearing;

- (ii) is a relative of the individual requesting the hearing;
- (iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
- (iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

- (1) The President of the Hospital, after consulting with the President of the Medical Staff and the Chief Medical Officer, will appoint an attorney to serve as the Presiding Officer. The Presiding Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing. The Presiding Officer will not act as an advocate for either side at the hearing.
- (2) The Presiding Officer will:
 - (i) schedule and conduct a pre-hearing conference;
 - (ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iv) maintain decorum throughout the hearing;
 - (v) determine the order of procedure;
 - (vi) rule on matters of procedure and the admissibility of evidence; and
 - (vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
- (3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
- (4) The Presiding Officer may participate in the private deliberations of the Hearing Panel, be a legal advisor to it, and may draft the report of the

Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

- (1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies, the President of the Hospital, after consulting with the President of the Medical Staff and the Chief Medical Officer, may appoint a Hearing Officer.
- (2) The Hearing Officer, who should be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.
- (3) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will refer to the Hearing Officer.

(d) Objections:

An objection to any member of the Hearing Panel, the Presiding Officer, or the Hearing Officer will be made in writing, within ten days of receipt of notice, to the President of the Hospital. The objection, which must include reasons to support it, must also be provided to the President of the Medical Staff. The President of the Medical Staff will be given a reasonable opportunity to comment on the objections. The President of the Hospital will rule on the objection and give notice to the parties. The President of the Hospital may request that the Presiding Officer make a recommendation as to the validity of the objection.

(e) Compensation:

Members of the Hearing Panel and the Presiding Officer may be compensated for their service by the Hospital. The individual requesting the hearing will be offered the opportunity to contribute to the compensation paid.

7.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

- (a) The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.
- (b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.
- (c) Neither the individual who requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted the employees or members and confirmed their willingness to meet. Any employee or member may agree or decline to be interviewed by or on behalf of the individual who requested the hearing. If an employee or member who is on the Medical Executive Committee's witness list agrees to be interviewed pursuant to this provision, counsel for the Medical Executive Committee may be present for the interview.

7.B.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

- (a) the pre-hearing conference will be scheduled at least 14 days prior to the hearing;
- (b) the parties will exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and
- (c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.B.3. Witness List:

- (a) At least 10 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list will include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party. If the witness list is amended, the other party

may request a postponement if additional time is needed to prepare for the new witness.

7.B.4. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree, in writing, that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the Medical Executive Committee;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information shall not waive any privilege.
- (c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff.

7.B.5. Pre-Hearing Conference:

- (a) The Presiding Officer will require the individual and the Medical Executive Committee (or a representative of each, who may be counsel) to participate in a pre-hearing conference.
- (b) All objections to exhibits or witnesses will be submitted, in writing, **five days** in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

- (d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.
- (e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

7.B.6. Stipulations:

The parties, and their counsel, will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

7.B.7. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing:

- (a) a pre-hearing statement that either party may choose to submit;
- (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and
- (c) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

The Presiding Officer will determine the length of the hearing at the pre-hearing conference. As a general rule, it is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.2. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;

- (3) to cross-examine any witness;
 - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;
 - (5) to submit a written statement at the close of the hearing; and
 - (6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

7.C.3. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral testimony will be taken on oath or affirmation administered by any authorized person.

7.C.4. Order of Presentation and Burden:

The Medical Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present clear and convincing evidence that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.C.5. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President of the Hospital or the President of the Medical Staff.

7.C.7. Presence of Hearing Panel Members:

A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, that Hearing Panel member must read the portion of the hearing from which he or she was absent.

7.C.8. Failure to Appear:

Failure to appear and proceed at the hearing, without good cause as determined by the Presiding Officer, will constitute a waiver of the right to a hearing and the matter will be forwarded to the Board for final action.

7.C.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the President of the Hospital on a showing of good cause.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

7.D.3. Disposition of Hearing Panel Report:

The Hearing Panel will deliver its report to the President of the Hospital. The President of the Hospital will send by special notice a copy of the report to the individual who requested the hearing. The President of the Hospital will also provide a copy of the report to the President of the Medical Staff and the Chief Medical Officer.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

- (a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the President of the Hospital in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.
- (b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

- (a) there was substantial failure by the Hearing Panel or the Presiding Officer to comply with this Policy or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

7.E.3. Time, Place, and Notice:

Whenever an appeal is requested, the Board Chairperson will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the Board Chairperson may appoint a Review Panel, composed of not less than three persons, either members of the Board or others, including but not limited to persons outside the Hospital.
- (b) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond.
- (c) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Executive Committee and Hearing Panel and any other information that it deems relevant.

- (d) In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (e) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new and relevant evidence that could not have been presented at the hearing or that any opportunity to admit it at the hearing was improperly denied.
- (f) The Review Panel will prepare a report recommending final action to the Board.

7.F. BOARD ACTION

7.F.1. Final Decision of the Board:

- (a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board will consider the matter and take final action.
- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable).
- (c) The Board may adopt, modify, or reverse any recommendation it receives or refer the matter for further review and recommendation to any individual or committee. Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may also make its own decision.
- (d) The Board will render its final decision in writing, including the basis for its decision. The final decision will be sent by special notice to the individual. A copy will also be provided to the President of the Medical Staff.
- (e) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

7.F.2. Right to One Hearing and One Appeal Only:

No individual will be entitled to more than one hearing and one appeal on any matter.

ARTICLE 8

CONFLICTS OF INTEREST

- (a) All those involved in credentialing, privileging, and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose request is being considered or whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the process.
- (b) It is also essential that peers participate in credentialing, privileging, and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual with an actual or potential conflict of interest can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.
- (c) When performing a function outlined in this Policy, or any of the other medical staff governance documents, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.
- (d) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the President of the Medical Staff (or the Vice President of the Medical Staff if the President of the Medical Staff is the person with the potential conflict), the Chief Medical Officer, the applicable department chief, or the applicable committee chairperson.
- (e) Additionally, the subject member is obligated to notify the President of the Medical Staff, the Chief Medical Officer, or the applicable department chief or committee chairperson of any known or suspected conflicts of interest who are involved in reviewing the member's request or performance. Any potential conflict of interest that is not timely raised will be deemed to be waived.
- (f) The President of the Medical Staff, the applicable department chief or the applicable committee chairperson, will make a final determination as to whether the provisions in this Article should be triggered or may submit the issue of whether there is a conflict of interest to a vote of the entire committee or department.
- (g) The fact that a chief, chairperson, or a member is in the same specialty as a member whose request is being considered or performance is being reviewed does

not automatically create a conflict. In addition, an assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

- (h) The fact that a department or committee member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of an actual conflict of interest.
- (i) Conflict of Interest Guidelines, which are attached as Appendix B, may be used to provide guidance in addressing potential conflict of interest situations.

ARTICLE 9

AMENDMENTS AND ADOPTION

- (a) The amendment process for this Policy is set forth in the Medical Staff Bylaws.
- (b) This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Medical Staff Rules and Regulations, and Hospital or Medical Staff policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____ (Date)

Approved by the Board: _____ (Date)

APPENDIX A

ADVANCED PRACTICE CLINICIAN STAFF

The Advanced Practice Clinician Staff consists of the following:

- Acupuncturists
- Advanced Practice Registered Nurses, including certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical nurse specialists (CNS), and certified nurse practitioners (CNP)
- Chiropractor
- Physician Assistants (PA-C)
- Psychologists

APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation						
	Provide Information	Individual Reviewer	Committee Member				Hearing Panel
			Leadership Council	PRC	MEC	Ad Hoc Investigating	
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	N	N	N	N	N
Relevant treatment relationship	Y	N	N	N	N	N	N
Significant financial relationship	Y	M	M	M	M	N	N
Direct competitor	Y	M	M	M	M	N	N
Close friends	Y	M	M	M	M	N	N
History of conflict	Y	M	M	M	M	N	N
Personally involved in care of patient (but not subject of review)	Y	M	M	M	M	N	N
Other than Leadership Council, MEC, or department chief, reviewed at prior level	Y	M	M	M	M	N	N
Raised the concern	Y	M	M	M	N	N	N

- Y** – means the individual may serve in the indicated role, no extra precautions are necessary.
- N** – means the individual may not serve in the indicated role and should be recused in accordance with the rules for recusal (*see next page*). If the facts and circumstances are contentious or otherwise unclear, the Chairperson of the Leadership Council, PIC, or MEC may submit the issue to a vote of the entire committee.
- M** – means the Interested Member may have a conflict of interest. The President of the Medical Staff or the chairperson of the committee should consider the facts and circumstances and determine whether the conflict would make it difficult for the individual to be fair and objective in performing a review, whether the individual’s service might inhibit the full and fair discussion of the issue, skew the recommendation of the committee, or otherwise be unfair to the practitioner under review. In considering the facts and circumstances, the President of the Medical Staff or the applicable chairperson may determine that a potential conflict is not significant enough to prohibit the person from serving in the designated role because of the check and balance provided by the multiple levels of review and the fact that the committee at issue has no disciplinary authority. The President of the Medical Staff or the chairperson of the applicable committee may submit the issue of whether there is a conflict of interest to

a vote of the entire committee. No Medical Staff member has the right to demand the recusal of another member.

CONFLICT OF INTEREST GUIDELINES (cont'd.)

GUIDELINES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The committee chairperson should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member ¹ at the meeting	<p>The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation.</p> <p>When the matter implicating the conflict of interest is ready for consideration, the committee chairperson will note that the Interested Member will be excused from the meeting prior to the group’s deliberation and decision-making.</p> <p>Prior to being excused, the Interested Member may provide information and answer any questions regarding the following:</p> <ul style="list-style-type: none"> (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or are relevant to the matter under consideration; (iv) the Interested Member’s prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee’s activities and present the Investigating Committee’s written report and recommendations to the Medical Executive Committee prior to being excused from the meeting); and (v) how the committee has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee’s deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee. The minutes should reflect that the Interested Member was excused from the meeting prior to deliberation and decision-making.

¹ “Interested Member” refers to the individual with a potential conflict of interest.

KENT HOSPITAL

MEDICAL STAFF BYLAWS

Reviewed and Approved by Medical Executive Committee

February 20, 2020

Reviewed and Approved by the Medical Staff

July 6, 2020

Reviewed and Approved by the Board of Directors

July 23, 2020

Horty, Springer & Mattern, P.C.

MEDICAL STAFF BYLAWS
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APPENDIX A

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in the Medical Staff documents are set forth in the Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. Medical Staff leaders will strive to be fair under the circumstances.

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a Medical Staff Leader, a Medical Staff committee, or a member of Hospital Administration, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees. Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the medical staff governance documents.
- (2) When a member of the Medical Staff is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

- (1) Medical Staff dues will be voted on by the Medical Staff and may vary by category. Dues will be used for necessary expenses of the Medical Staff.
- (2) Dues will be payable biannually. Failure to pay dues will result in ineligibility for reappointment.
- (3) Signatories to the Hospital Medical Staff account will be the President of the Medical Staff and Secretary-Treasurer.

1.E. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify Medical Staff officers, department and committee chairpersons, division chiefs, committee members, other members of the Medical Staff, and authorized representatives, who act for and on behalf

of the Hospital in discharging their responsibilities and professional review activities pursuant to these Bylaws and other Hospital or Medical Staff policies, procedures or rules and regulations, when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

2.A. GENERAL

- (1) Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff set forth in the Credentials Policy are eligible to apply for appointment to one of the categories listed below. The categories, along with the respective prerogatives and responsibilities, are summarized in the chart attached as Appendix A to these Bylaws.
- (2) At reappointment, any member of the Medical Staff who has not had sufficient patient activity at the Hospital may be requested to provide quality data and other information to assist in an appropriate assessment of current clinical competence.

2.B. ACTIVE STAFF

2.B.1. Qualifications:

- (a) The Active Staff will consist of members of the Medical Staff who are a physician, dentist or podiatrist, and who:
 - (1) are involved in at least 50 patient contacts at the Hospital or Hospital-licensed sites during the two-year appointment term; OR
 - (2) do not meet the activity requirements of this category but have demonstrated a commitment to the Medical Staff through service on Medical Staff or Hospital committees, attendance at Medical Staff, department, division, or committee meetings, or active participation in performance/quality improvement functions for at least 20 documented hours during the two-year appointment term. (Members are responsible for providing documentation to support compliance with this activity requirement.)
- (b) An Active Staff member may request a transfer to the Courtesy Staff if he or she can definitively demonstrate to the Credentials Committee that his or her practice patterns have significantly changed and that he or she will be involved in fewer than 50 patient contacts during the next two-year appointment term.

2.B.2. Prerogatives:

Active Staff members may:

- (a) admit patients consistent with the delineation of privileges granted;

- (b) vote in general and special meetings of the Medical Staff and applicable department, division, and committee meetings;
- (c) hold office, serve as department chief, division chief, or committee chairperson; and
- (d) exercise clinical privileges granted.

2.B.3. Responsibilities:

Active Staff members must, when requested, assume all the responsibilities of membership on the Active Staff, consistent with the clinical privileges granted, including:

- (a) serving on committees, as requested;
- (b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;
- (c) participating in the professional practice evaluation and performance improvement processes;
- (d) providing care for unassigned patients;
- (e) accepting inpatient consultations, when on call; and
- (f) paying application fees and dues.

2.B.4. Senior Active Status:

- (a) Members of the Active Staff who have provided 20 years of service at the Hospital or are 65 years of age or older and have a minimum of 10 years of service at the Hospital may request Senior Active Status. Members who have been granted Senior Active Status may be excused from rotational obligations, including providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department.
- (b) The request will be reviewed by the department chief, and a recommendation made to the Medical Executive Committee. In reviewing a request for Senior Active Status, consideration will be given to need and the effect on others who serve on the Emergency Department call roster. The Medical Executive Committee's recommendation will be subject to final action by the Board.
- (c) A member who is granted Senior Active Status may, at a later date, be required to resume on-call duties if a recommendation is made by the Medical Executive

Committee and approved by the Board, that call coverage in the member's specialty area is not adequate.

- (d) In all other respects, this category follows the qualifications, prerogatives, and responsibilities of the Active Staff.

2.C. AFFILIATE STAFF

2.C.1. Qualifications:

- (a) The Affiliate Staff will consist of members of the Medical Staff who:
 - (1) desire to be associated with, but who do not intend to establish an inpatient practice at, the Hospital;
 - (2) are interested in pursuing professional and educational opportunities available at the Hospital; and
 - (3) satisfy the qualifications for appointment set forth in the Credentials Policy but are exempt from the qualifications pertaining to response times, location within the geographic service area, emergency call, and coverage arrangements.
- (b) The grant of appointment to the Affiliate Staff is a courtesy only, which may be lifted by the Board upon recommendation of the Medical Executive Committee, with no right to a hearing or appeal.

2.C.2. Prerogatives and Responsibilities:

Affiliate Staff members:

- (a) may attend Medical Staff meetings (without vote) and applicable department meetings (without vote);
- (b) may not hold office or serve as department or division chief;
- (c) may be appointed to serve on committees (with vote), including as chairperson;
- (d) may attend educational activities sponsored by the Medical Staff and the Hospital;
- (e) are encouraged to communicate directly with members about the care of any patients referred;
- (f) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

- (g) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;
- (h) are not granted clinical privileges to practice on an inpatient basis and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital; and
- (i) must pay application fees and dues.

2.D. COURTESY STAFF

2.D.1. Qualifications:

The Courtesy Staff will consist of members of the Medical Staff who are a physician, dentist or podiatrist, and who:

- (a) are new members of the Medical Staff (unless recruited by the Hospital to serve in a leadership position in which case the member will be appointed to the Active Staff) and are subject to the initial focused professional practice evaluation process¹; OR
- (b) are existing members who are involved in fewer than 50 patient contacts at the Hospital during the two-year appointment term (involvement in 50 or greater patient contacts may result in transfer to the Active Staff); AND
- (c) are members of the active staff at another hospital, unless their clinical specialty does not support an active inpatient practice (e.g., dermatology, allergy) and the Medical Executive Committee recommends an exception which is approved by the Board.

2.D.2. Prerogatives and Responsibilities:

Courtesy Staff members:

- (a) may admit patients consistent with the delineation of privileges granted;
- (b) may attend and participate in Medical Staff meetings (without vote), department meetings (without vote), and division meetings (without vote);
- (c) may not hold office or serve as department or division chief;
- (d) may be invited to serve on committees, including as chairperson (with vote);

¹ After completion of the initial focused professional practice evaluation process, the member may seek to be moved to a different staff category.

- (e) may exercise clinical privileges as are granted;
- (f) must provide specialty coverage, as requested, for the Emergency Department for unassigned patients;
- (g) must cooperate in the professional practice evaluation and performance improvement processes; and
- (h) must pay application fees and dues.

2.E. CONSULTING STAFF

2.E.1. Qualifications:

The Consulting Staff will consist of members of the Medical Staff who are a physician, dentist, podiatrist, or telemedicine practitioner and who:

- (a) are of demonstrated professional ability and expertise and provide a service not otherwise available on the Active Staff (should the service become readily available on the Active Staff, Consulting Staff members would not be eligible for reappointment to the Consulting Staff and would have to transfer to a different staff category if they desire continued appointment);
- (b) provide services at the Hospital at the request of other members of the Medical Staff; and
- (c) are members of the active staff at another hospital, unless their clinical specialty does not support an active inpatient practice (e.g., dermatology, allergy) and the Medical Executive Committee recommends an exception which is approved by the Board.

2.E.2. Prerogatives and Responsibilities:

Consulting Staff members:

- (a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff;
- (b) may attend meetings of the Medical Staff (without vote) and the applicable department and division meetings (without vote), and applicable committee meetings (with vote);
- (c) may not hold office or serve as department or division chief;
- (d) may be invited to serve on committees, including as chairperson (with vote);

- (e) may exercise clinical privileges granted;
- (f) must, as requested, provide specialty coverage for the Emergency Department for unassigned patients;
- (g) must cooperate in the professional practice evaluation and performance improvement processes; and
- (h) must pay application fees and dues (telemedicine practitioners are exempt from paying dues).

2.F. HONORARY STAFF

2.F.1. Qualifications:

- (a) The Honorary Staff will consist of members of the Medical Staff who are a physician and who:
 - (1) have a record of previous long-standing service to the Hospital, have retired from the active practice of medicine in the Hospital, and, in the discretion of the Medical Executive Committee, are in good standing at the time of initial application for membership on the Honorary Staff; or
 - (2) are recognized for outstanding or noteworthy contributions to the medical sciences.
- (b) The grant of appointment to the Honorary Staff is a courtesy only, which may be lifted by the Board upon recommendation of the Medical Executive Committee, with no right to a hearing or appeal.
- (c) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

- (a) are not granted clinical privileges and, therefore, may not admit, consult, or attend to patients;
- (b) may attend Medical Staff meetings (without vote), department meetings (without vote), and division meetings (without vote);
- (c) may not hold office or serve as department or division chief;
- (d) may be invited to serve on committees, including as chairperson (with vote);

- (e) are entitled to attend educational programs of the Medical Staff and the Hospital; and
- (f) are not required to pay application fees or dues.

2.G. ADVANCED PRACTICE CLINICIAN STAFF

2.G.1. Qualifications:

- (a) The Advanced Practice Clinician Staff consists of health care professionals and scientists who have been appointed to this category of the Medical Staff.
- (b) In order to be eligible for clinical privileges, an advanced practice clinician must have a minimum of 50 patient contacts at the Hospital or a Hospital-licensed site during the two-year appointment term.

2.G.2. Prerogatives and Responsibilities for Advanced Practice Clinician Staff Members with Clinical Privileges:

Advanced Practice Clinician Staff members with clinical privileges:

- (a) may attend and participate in Medical Staff meetings (with vote);
- (b) are expected to attend department meetings (without vote);
- (c) may not hold office or serve as department or division chief;
- (d) may be invited to serve on committees, including as chairperson (with vote);
- (e) must cooperate in the professional practice evaluation and performance improvement processes;
- (f) may exercise such clinical privileges as granted but may not admit under their own name; and
- (g) must pay application fees and dues.

2.G.3. Prerogatives and Responsibilities for Advanced Practice Clinician Members without Clinical Privileges:

Advanced Practice Clinician Staff members without clinical privileges:

- (a) may attend and participate in Medical Staff and department meetings (without vote);

- (b) may not hold office or serve as department or division chief;
- (c) may not serve on committees;
- (d) are not subject to the professional practice evaluation and performance improvement processes;
- (e) are not granted clinical privileges; and
- (f) must pay application fees and dues.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The Medical Staff will have the following officers:

- President of the Medical Staff;
- Vice President of the Medical Staff;
- Secretary-Treasurer; and
- Immediate Past President of the Medical Staff.

3.B. ELIGIBILITY CRITERIA

Only those members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff (unless an exception is recommended by the Medical Executive Committee and approved by the Board). They must:

- (1) have served on the Active Staff for at least two years;
- (2) have no pending adverse recommendations concerning appointment or clinical privileges;
- (3) not presently be serving as a medical staff officer, board member, or department chief at any other unaffiliated hospital and will not so serve during their terms of office;
- (4) be willing to faithfully discharge the duties and responsibilities of the position;
- (5) have experience in a leadership role, experience through committee participation, or other involvement in Medical Staff/Hospital performance improvement functions, for at least two years;
- (6) participate in medical staff leadership training as determined by the Medical Executive Committee;
- (7) have demonstrated an ability to work well with others; and
- (8) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with a hospital or health care system that competes

with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff will:

- (a) act in coordination and cooperation with the President of the Hospital, the Chief Medical Officer, and the Board in matters of mutual concern involving the care of patients in the Hospital;
- (b) represent and communicate the views, policies, and needs, and report on the activities, of the Medical Staff to the President of the Hospital, Chief Medical Officer, and the Board;
- (c) call, preside at, and be responsible for the agenda of meetings of the Medical Staff;
- (d) serve as a member and chairperson of the Medical Executive Committee;
- (e) in consultation with the Chief Medical Officer, appoint the members and the chairperson of each committee of the Medical Staff;
- (f) in consultation with the Chief Medical Officer, recommend Medical Staff representatives to Hospital committees and administrative staff to committees of the Medical Staff;
- (g) be an *ex officio* member, with vote, on all Medical Staff committees;
- (h) promote adherence to the medical staff governance documents and to the policies and procedures of the Hospital;
- (i) perform functions authorized in these Bylaws and other applicable policies, including collegial intervention in the Credentials Policy; and
- (j) serve as a member of the Board.

3.C.2. Vice President of the Medical Staff:

The Vice President of the Medical Staff shall:

- (a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff when the President of the Medical Staff is unavailable within a reasonable period of time;
- (b) serve as a member of the Medical Executive Committee;
- (c) assume all such additional duties as are assigned by the President of the Medical Staff or the Medical Executive Committee; and
- (d) automatically succeed the President of the Medical Staff upon completion of the President's term of office, unless as otherwise determined by the Leadership Council.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer will:

- (a) cause to be kept accurate and complete minutes of meetings of the Medical Executive Committee and the Medical Staff;
- (b) oversee the collection of and accounting for any Medical Staff dues and other assessments and make disbursements as authorized;
- (c) serve as a member of the Medical Executive Committee;
- (d) perform other duties as are assigned by the President of the Medical Staff or the Medical Executive Committee; and
- (e) automatically succeed the Vice President of the Medical Staff upon completion of the Vice President's term of office, unless as otherwise determined by the Leadership Council.

3.C.4. Immediate Past President of the Medical Staff:

The Immediate Past President of the Medical Staff will:

- (a) serve as an advisor to the President of the Medical Staff and other Medical Staff Leaders;
- (b) serve as a member of the Medical Executive Committee; and
- (c) perform other duties as are assigned by the President of the Medical Staff or the Medical Executive Committee.

3.D. NOMINATION AND ELECTION PROCESS

3.D.1. Nominating Process:

- (a) Not less than 45 days prior to the annual meeting of the Medical Staff, the Leadership Council will prepare a slate of nominees for the Secretary-Treasurer and at-large position(s) on the Medical Executive Committee, as needed. Notice of the nominees will be provided to the Medical Staff at least 30 days prior to the election. The Leadership Council may also recommend that an individual serving in an officer position not automatically succeed to another officer position and nominate another member to serve in the open position.
- (b) Additional nominations may be submitted, in writing, by a petition signed by at least 10% of the voting members of the Medical Staff for the nominee to serve as the Secretary-Treasurer or at-large member of the Medical Executive Committee. The petition must be presented to the Leadership Council at least 14 days prior to the annual meeting.
- (c) In order for a nominee to be placed on the ballot, the candidate must be willing to serve and must, in the judgment of the Leadership Council, satisfy the qualifications in Section 3.B of these Bylaws.

3.D.2. Election:

- (a) Except as provided below, the election will take place at the annual meeting of the Medical Staff. If there are two or more candidates for the office or position, the vote will be by written ballot.
- (b) If any voting member of the Medical Staff is unable to attend the meeting, the member may vote by absentee ballot. The absentee ballots must be returned to the Medical Staff Office by noon on the day before the annual meeting. The absentee ballots will be counted prior to the meeting and will be included in the vote at the meeting.
- (c) In the alternative, the Medical Executive Committee may determine that the election will be held by electronic or written ballot. Ballots must be received by the date indicated on the ballot.
- (d) The candidate receiving a majority of the votes cast will be elected. Those who receive a majority of the votes cast will be elected, subject to Board confirmation.
- (e) If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes.
- (f) Nominations from the floor will not be accepted.

3.E. TERM OF OFFICE, VACANCIES, AND REMOVAL

3.E.1. Term of Office:

- (a) Officers will assume office on the first day of the Medical Staff year.
- (b) Unless otherwise specified, officers will serve a two-year term.
- (c) The at-large members of the Medical Executive Committee will each serve a two-year term and will, for the sake of continuity, be elected in alternating years.

3.E.2. Vacancies:

- (a) If there is a vacancy in the office of President of the Medical Staff, the Vice President of the Medical Staff will serve until the end of the unexpired term of the President of the Medical Staff.
- (b) If there is a vacancy in the office of Vice President of the Medical Staff, the Secretary-Treasurer will serve until the end of the unexpired term of the Vice President of the Medical Staff.
- (c) If there is a vacancy in the office of Secretary-Treasurer or at-large member of the Medical Executive Committee, the Medical Executive Committee will appoint an individual who satisfies the qualifications set forth in Section 3.B of these Bylaws to fill the office for the remainder of the term or until a special election can be held, at the discretion of the Medical Executive Committee.
- (d) If there is a vacancy in the office of the Immediate Past President of the Medical Staff, then the next most recent Immediate Past President of the Medical Staff will serve. If this succession is not possible, any vacancies will be filled by the Medical Executive Committee.

3.E.3. Removal:

- (a) Removal of an elected officer or an at-large member of the Medical Executive Committee may be effectuated by a two-thirds vote of the voting members of the Medical Staff or a three-fourths vote of the Medical Executive Committee for:
 - (1) failure to comply with applicable policies, Bylaws, or the Rules and Regulations;
 - (2) failure to perform the duties of the position held;
 - (3) conduct detrimental to the interests of the Medical Staff or the Hospital;

- (4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or
 - (5) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws.
- (b) Prior to scheduling a meeting to consider removal, a representative from the Medical Staff or the Medical Executive Committee will meet with and inform the individual of the reasons for the proposed removal proceedings.
 - (c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the Medical Staff, or the Medical Executive Committee, as applicable, prior to a vote on removal. A vote on removal will be effective when approved by the Board.

ARTICLE 4

CLINICAL DEPARTMENTS AND DIVISIONS

4.A. ORGANIZATION

4.A.1. Organization of Departments:

- (a) The Medical Staff may be organized into clinical departments or divisions as listed in the Medical Staff Organization Manual.
- (b) As described in greater detail in the Medical Staff Organization Manual, the Medical Executive Committee may create, eliminate, or otherwise reorganize the department structure, including the creation of divisions.

4.A.2. Assignment to Departments:

- (a) Upon initial appointment to the Medical Staff, each member will be assigned to a clinical department, and division, if applicable. Assignment to a particular department, or division, does not preclude an individual from seeking and being granted clinical privileges typically associated with another department or division.
- (b) An individual may request a change in department, or division, assignment to reflect a change in the individual's clinical practice.

4.A.3. Functions of Departments:

The departments are organized for the purpose of performing and facilitating the following functions:

- (a) monitoring and evaluating the quality and appropriateness of the care of patients;
- (b) monitoring the practice of individuals with clinical privileges in a given department;
- (c) providing appropriate specialty coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents;
- (d) promoting and supporting pertinent continuing medical education programs; and
- (e) fostering an atmosphere of professional decorum within the department.

4.B. DEPARTMENT CHIEFS4.B.1. Qualifications:

In order to be eligible to serve as a department chief, an individual must:

- (a) be an Active Staff member;
- (b) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and
- (c) satisfy the eligibility criteria in Section 3.B, unless an exception is made by the President of the Hospital, and approved by the Board.

4.B.2. Appointment and Term of Office for Department Chiefs:

- (a) When there is a vacancy or an anticipated vacancy in a department chief position, a search committee will be formed and will include the President of the Hospital, the Leadership Council, and medical staff members from the relevant department selected by the Leadership Council. The search committee will recommend an individual to serve as the department chief. This recommendation is subject to final approval by the Board.
- (b) Except as otherwise provided by contract, department chiefs will serve a three-year term and may be appointed to serve additional terms.

4.B.3. Performance Evaluation for Department Chiefs:

- (a) A performance evaluation of the department chief may be initiated by the Chief Medical Officer. The Leadership Council will assist in this function.
- (b) The following factors may be addressed as part of the evaluation:
 - (1) quality and support of the department as it interfaces with other Hospital departments;
 - (2) communication, coordination, quality and service of care within the department;
 - (3) effectiveness of the performance improvement program; and
 - (4) where appropriate, contribution to patient care, education and research.
- (c) The Leadership Council will prepare a written report of the evaluation and provide a copy to the relevant department chief.

- (d) The Leadership Council will monitor the department chief's improvement activities and report progress to the President of the Hospital and the Board.

4.B.4. Removal of Department Chief:

- (a) A recommendation to remove a department chief may be made by a two-thirds vote of the Medical Executive Committee after reasonable notice and opportunity to be heard. Grounds to recommend removal include:
- (1) failure to comply with the Bylaws or applicable policies, or rules and regulations;
 - (2) failure to perform the duties of the position held;
 - (3) conduct detrimental to the interests of the Medical Staff or the Hospital;
 - (4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or
 - (5) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws.
- (b) Prior to scheduling a meeting to consider a recommendation for removal, a representative from the Medical Executive Committee will meet with and inform the individual of the reasons for the proposed removal proceedings.
- (c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the Medical Executive Committee prior to a vote on removal.
- (d) A final decision to remove a department chief will be made by the Board.

4.B.5. Duties of Department Chiefs:

- (a) Each department chief is responsible for the following functions, either individually or in collaboration with Hospital personnel:
- (1) all clinically-related activities of the department;
 - (2) all administratively-related activities of the department, unless otherwise provided for by the Hospital;
 - (3) reviewing and evaluating applications for initial appointment (including participation in the interview of applicants), reappointment, and clinical privileges;

- (4) evaluating individuals who are granted privileges in order to confirm competence;
- (5) recommending criteria for clinical privileges that are relevant to the care provided in the department;
- (6) continuing surveillance of the professional performance of individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations;
- (7) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;
- (8) the integration of the department into the primary functions of the Hospital;
- (9) the coordination and integration of interdepartment and intradepartment services;
- (10) the development and implementation of policies and procedures that advance quality and guide and support the provision of care, treatment, and services;
- (11) recommendations for a sufficient number of qualified and competent individuals to provide care, treatment, and services;
- (12) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- (13) continuous assessment and improvement of the quality of care, treatment, and services provided;
- (14) maintenance of quality monitoring programs, as appropriate;
- (15) the orientation and continuing education of members in the department;
- (16) recommendations for space and other resources needed by the department; and
- (17) performing functions authorized in the Credentials Policy, including collegial intervention efforts.

- (b) The department chief may create an advisory committee consisting of members of the department to assist the chief in the discharging the following responsibilities:
 - (1) conduct of medical review of clinical work;
 - (2) propose policies for the efficient operation of the department;
 - (3) develop and evaluate the education program within the department;
 - (4) consult with Administration on purchase of equipment; and
 - (5) otherwise serve as a resource to the department chief.

4.C. DIVISIONS

4.C.1. Qualifications, Selection, Term, and Removal of Division Chief:

- (a) Division chiefs will be selected following the process used to select department chiefs.
- (b) Except as otherwise provided by contract, division chiefs will serve a three-year term and may be appointed to serve additional terms.
- (c) Division chiefs will be removed following the process used to remove department chiefs.

4.C.2. Duties of Division Chief:

- (a) The division chief will carry out the duties requested by the department chief, including but not limited to the following:
 - (1) reviewing and reporting on applications for initial appointment, reappointment, and clinical privileges;
 - (2) evaluating individuals who are granted privileges in order to confirm competence; and
 - (3) continuing surveillance of the professional performance of individuals in the division who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations.
- (b) Divisions are not required to hold regularly scheduled meetings. Minutes and reports are not required unless the division is making a formal recommendation to the department chief, the Credentials Committee, or the Medical Executive Committee.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. GENERAL5.A.1. Appointment:

- (a) This Article and the Medical Staff Organization Manual outline the committees of the Medical Staff that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (b) Except as otherwise provided by these Bylaws or the Medical Staff Organization Manual, the President of the Medical Staff, in consultation with the Chief Medical Officer, will appoint the members and the chairperson of each committee of the Medical Staff. Committee chairpersons should generally satisfy the criteria in Section 3.B of these Bylaws.
- (c) The President of the Medical Staff, in consultation with the Chief Medical Officer, will also recommend Medical Staff representatives to Hospital committees.
- (d) The President of the Hospital, in consultation with the Chief Medical Officer and President of the Medical Staff, will make appointments of administrative staff to committees of the Medical Staff. Administrative staff will serve on committees of the Medical Staff without the right to vote (unless otherwise specified).
- (e) Chairpersons and members of standing committees will be appointed for an initial term of two years but may be reappointed for additional terms.
- (f) Chairpersons and members of standing committees may be removed and vacancies filled at the discretion of the President of the Medical Staff, in consultation with the Chief Medical Officer.
- (g) The President of the Medical Staff will be an *ex officio* member, with vote, on all Medical Staff committees. The Vice President of the Medical Staff, the Secretary-Treasurer, and the Immediate Past President of the Medical Staff will be *ex officio* members, with vote, on all Medical Staff committees to which they are appointed.
- (h) The President of the Hospital and Chief Medical Officer will be *ex officio* members, without vote, on all Medical Staff committees (unless otherwise specified).

5.A.2. Meetings, Reports and Recommendations:

Except as otherwise provided, Medical Staff committees will meet as often as necessary to accomplish their functions and will maintain minutes which include their findings, proceedings, and actions. Medical Staff committees will make written reports to the Medical Executive Committee through committee minutes. Minutes of committee meetings will be kept and maintained under the supervision of the Medical Staff Office.

5.B. MEDICAL EXECUTIVE COMMITTEE5.B.1. Composition:

- (a) The Medical Executive Committee will include the following voting members:
 - (1) President of the Medical Staff, Vice President of the Medical Staff, Secretary-Treasurer, and Immediate Past President of the Medical Staff;
 - (2) department chiefs;
 - (3) chief of the division of hospitalist medicine;
 - (4) Designated Institutional Official;
 - (5) at least one at-large member from the Active Staff; and
 - (6) at least one at-large member from the Advanced Practice Clinician Staff.
- (b) To help facilitate adequate representation from clinical specialties, including community providers, the Medical Executive Committee may appoint additional members of the Medical Staff to serve on the committee, with vote.
- (c) The following will serve as *ex officio* members of the Medical Executive Committee, without vote: President of the Hospital, Chief Medical Officer, Chairperson of the Credentials Committee, Chairperson of the Provider Refinement Committee, Chief Nursing Officer, and Director of the Office of the Medical Staff.
- (d) The Leadership Council will determine which, if any, Care of New England Executive Chiefs will serve as members of the Medical Executive Committee, including the voting status, on the committee, of each Executive Chief.
- (e) The President of the Medical Staff will serve as chairperson of the Medical Executive Committee, with vote.

- (f) The Chairperson of the Board, or another member of the Board appointed by the Chairperson, may attend meetings of the Medical Executive Committee, *ex officio*, without vote.
- (g) Other individuals, including but not limited to the Vice President of Finance, may be invited to attend meetings of the Medical Executive Committee as guests, without vote, in order to assist the Medical Executive Committee in its discussions and deliberations regarding an issue on its agenda. These individuals are an integral part of the committee's functions and are bound by the same confidentiality requirements as members of the Medical Executive Committee.

5.B.2. Duties:

The Medical Executive Committee has primary oversight authority related to the professional activities and functions of the Medical Staff and to performance improvement activities. This authority may be removed or modified by amending these Bylaws and related policies. The Medical Executive Committee is responsible for the following:

- (a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are collectively empowered to act in urgent situations between Medical Executive Committee meetings);
- (b) recommending directly to the Board on at least the following:
 - (1) the Medical Staff's structure;
 - (2) the mechanism used to review credentials and to delineate individual clinical privileges;
 - (3) applicants for appointment and reappointment;
 - (4) delineation of clinical privileges for each eligible individual;
 - (5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;
 - (6) the mechanism by which appointment to the Medical Staff may be terminated;
 - (7) hearing procedures;
 - (8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate; and

- (9) urgent amendments to the rules and regulations;
- (c) consulting with Administration on quality-related aspects of contracts for patient care services;
- (d) providing oversight and guidance with respect to continuing medical education activities;
- (e) reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;
- (f) providing leadership in activities related to patient safety;
- (g) providing oversight in the process of analyzing and improving patient satisfaction;
- (h) taking reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff members, including initiating investigations, when warranted;
- (i) ensuring that, at least every three years, the Bylaws and applicable policies are reviewed and updated as needed;
- (j) providing and promoting effective liaison among the Medical Staff, Hospital Administration, and the Board;
- (k) recommending clinical services, if any, to be provided by telemedicine and the process to be followed in evaluating applicants for telemedicine privileges;
- (l) ensuring that standing orders are reviewed for consistency with nationally recognized and evidence-based guidelines;
- (m) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies; and
- (n) recommending changes to policies, procedures, delineation of clinical privileges, and other medical staff forms when such changes are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar, expression, or oversight.

5.B.3. Meetings:

The Medical Executive Committee will meet at least ten times a year and more often if necessary to fulfill its responsibilities and will maintain a permanent record of its proceedings and actions.

5.C. PERFORMANCE IMPROVEMENT FUNCTIONS

- (1) The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:
 - (a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;
 - (b) the Hospital's and individual practitioners' performance on Joint Commission (or other accreditation bodies) and Centers for Medicare & Medicaid Services core measures;
 - (c) medical assessment and treatment of patients;
 - (d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;
 - (e) the utilization of blood and blood components, including review of significant transfusion reactions;
 - (f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;
 - (g) appropriateness of clinical practice patterns;
 - (h) significant departures from established patterns of clinical practice;
 - (i) use of information about adverse privileging determinations regarding any practitioner;
 - (j) the use of developed criteria for autopsies;
 - (k) sentinel events, including root cause analyses and responses to unanticipated adverse events;
 - (l) nosocomial infections and the potential for infection;
 - (m) unnecessary procedures or treatment;
 - (n) appropriate resource utilization;
 - (o) education of patients and families;
 - (p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

- (q) accurate, timely, and legible completion of patients' medical records;
 - (r) the required content and quality of history and physical examinations, as well as the time frames required for completion, which are set forth in Article 9 of these Bylaws;
 - (s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance;
 - (t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board; and
 - (u) pain assessment, pain management, and safe prescribing, including opioid prescribing.
- (2) A description of the committees that carry out monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.D. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES

- (1) In accordance with the amendment provisions in the Medical Staff Organization Manual, the Medical Executive Committee may, upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. The Medical Executive Committee may also dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.
- (2) Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force will be performed by the Medical Executive Committee.
- (3) Special task forces will be created and their members and chairperson will be appointed by the President of the Medical Staff and the Medical Executive Committee. Such task forces will confine their activities to the purpose for which they were appointed and will report to the Medical Executive Committee.

ARTICLE 6

MEETINGS

6.A. GENERAL

6.A.1. Medical Staff Year:

The Medical Staff year is April 1 to March 30.

6.A.2. Regular Meetings:

- (a) The Medical Staff will hold quarterly meetings. The March meeting of the Medical Staff year will be considered the annual meeting.
- (b) Except as provided in these Bylaws or the Medical Staff Organization Manual, each department will meet quarterly and committees will meet as often as needed to perform their designated functions.
- (c) Departments and committees may provide the time for holding regular meetings and no other notice will be required.

6.A.3. Special Meetings:

- (a) A special meeting of the Medical Staff may be called by the President of the Medical Staff, a majority of the Medical Executive Committee, the President of the Hospital, the chairperson of the Board, or by a petition signed by at least 10% of the voting members of the Medical Staff. All requests for a special meeting of the Medical Staff will be submitted in writing to the President of the Medical Staff stating the purpose for the meeting.
- (b) A special meeting of any department or committee may be called by the President of the Medical Staff, the relevant department chief or committee chairperson, or by a petition signed by 10% of the voting members of the department or committee. All requests for a special meeting will be submitted in writing to the appropriate chairperson stating the purpose for the meeting.
- (c) No business will be transacted at any special meeting except that stated in the meeting notice.

6.B. PROVISIONS COMMON TO ALL MEETINGS

6.B.1. Prerogatives of the Presiding Chairperson:

- (a) The Presiding Chairperson is responsible for setting the agenda for any regular or special meeting of the Medical Staff, department, or committee.
- (b) The Presiding Chairperson has the discretion to conduct any meeting or allow participation in any meeting by telephone conference or videoconference.
- (c) The Presiding Chairperson has the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference, in the discretion of the Presiding Chairperson, it will not be binding. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom will prevail at all meetings and elections.

6.B.2. Notice:

- (a) Medical Staff members will be provided with at least 10 days' notice of regular meetings of the Medical Staff and regular meetings of departments and committees. The primary mechanism utilized for providing notice will be e-mail. Notice may also be provided via regular U.S. mail, Hospital mail, hand delivery, posting in a designated electronic or physical location, or telephone.
- (b) When a special meeting of the Medical Staff, department, or committee is called, the notice period will be at least 24 hours. Notice may be provided via regular U.S. mail, e-mail, or Hospital mail, or hand delivery.
- (c) Notices will state the date, time, and place of the meeting and will include the agenda.
- (d) The attendance of any individual at any meeting will constitute a waiver of that individual's notice of the meeting.

6.B.3. Quorum and Voting:

- (a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two members) will constitute a quorum. Exceptions to this general rule are as follows:
 - (1) for meetings of the Medical Executive Committee, the Credentials Committee, and the Provider Refinement Committee, the presence of at least 50% of the voting committee members will constitute a quorum; and
 - (2) for any amendments to these Medical Staff Bylaws, 25% of the voting members of the Medical Staff will constitute a quorum.

- (b) Once a quorum is established, the business of the meeting may continue and actions taken will be binding.
- (c) Recommendations and actions taken by the Medical Staff, department, and committee will be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority of the voting members present. At the discretion of the Presiding Chairperson, voting may be by written ballot.
- (d) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or committee may also be presented with a question by some other means (e.g., mail, e-mail, hand-delivery, website posting, or telephone), and their votes may be returned to the person and by the method designated in the notice. Except as otherwise provided in the Bylaws, a quorum for these votes will be the number of responses returned. The issue will be determined by a majority of the votes received.
- (e) Any individual who, by virtue of position, attends a meeting in more than one capacity will be entitled to only one vote.
- (f) Proxy voting will not be permitted.

6.B.4. Minutes:

- (a) Minutes of Medical Staff, department, and committee meetings will be prepared and will include a record of those in attendance, the recommendations made, and the votes taken on each matter.
- (b) Minutes of meetings of the Medical Staff, departments, and committees will be forwarded to the Medical Executive Committee.
- (c) The Board will be kept apprised of and act on the recommendations of the Medical Staff.
- (d) A permanent file of the minutes of meetings will be maintained by the Hospital.

6.B.5. Confidentiality:

- (a) Medical Staff business conducted by departments and committees is considered confidential and should be treated as such.
- (b) Members of the Medical Staff who have access to, or are the subject of, credentialing or peer review information must agree to maintain the confidentiality of the information. Failure to agree to maintain confidentiality and failure to maintain confidentiality would result in the denial of access to credentialing or peer review information.

- (c) Credentialing and peer review documents, and information contained in these documents, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy.
- (d) A breach of confidentiality may result in the imposition of disciplinary action.

6.C. ATTENDANCE

6.C.1. Regular and Special Meetings:

- (a) Members of the Medical Staff are encouraged to attend 50% of the Medical Staff and applicable department and committee meetings.
- (b) Members of the Medical Executive Committee are required to attend at least 70% of the committee's regular meetings. Failure to attend the required number of meetings may result in removal of the member from the committee as determined by the Leadership Council.
- (c) Members of the Credentials Committee and Provider Refinement Committee are required to attend at least 50% of the committee's regular meetings. Failure to attend the required number of meetings may result in removal of the member from the committee as determined by the Leadership Council.

ARTICLE 7

OVERVIEW OF BASIC STEPS AND PROCEDURES FOR APPOINTMENT,
CLINICAL PRIVILEGES, COLLEGIAL INTERVENTION, AND HEARINGS

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

7.A. QUALIFICATIONS FOR APPOINTMENT, REAPPOINTMENT,
AND CLINICAL PRIVILEGES

To be eligible to apply for initial appointment or reappointment to the Medical Staff, or for the granting of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in detail in the Credentials Policy.

7.B. PROCESS FOR CREDENTIALING AND PRIVILEGING

- (1) Complete applications for appointment and clinical privileges will be transmitted to the applicable department chief and, where applicable, the division chief, and the Chief Nursing Officer, who will review the individual's education, training, and experience and prepare a written report stating whether the individual meets all qualifications.
- (2) The Credentials Committee will review the report from the department chief (and, where applicable, the division chief), the application, and supporting materials and will make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the report of the department chief, and, if applicable, the division chief, to the Medical Executive Committee for review and recommendation.
- (3) The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee is to grant appointment, or reappointment, and clinical privileges, it will be forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual will be notified by the President of the Hospital of the right to request a hearing.
- (4) Temporary privileges may be granted by the Chief Medical Officer, in consultation with the President of the Medical Staff, with the written concurrence of the department chief and the Chief Medical Officer, to applicants for initial

appointment and to non-applicants, when there is an important patient care, treatment, or service need. The grant of temporary clinical privileges will not exceed 120 calendar days.

- (5) When the disaster plan has been implemented, the President of the Hospital or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

7.C. INDICATIONS AND PROCESS FOR ADMINISTRATIVE RELINQUISHMENT
OF APPOINTMENT AND CLINICAL PRIVILEGES

- (1) Appointment and clinical privileges may be administratively relinquished if an individual:
- (a) fails to do any of the following:
 - (i) complete medical records;
 - (ii) satisfy threshold eligibility criteria;
 - (iii) provide requested information;
 - (iv) attend a mandatory meeting to discuss issues or concerns;
 - (v) complete and comply with educational or training requirements;
 - (vi) comply with request for fitness for practice evaluation;
 - (vii) comply with request for competency assessment; or
 - (viii) notify the President of the Medical Staff or President of the Hospital of any change in any information on the application form; or
 - (b) is arrested, charged, indicted, convicted, or pleads guilty or no contest pertaining to any felony or misdemeanor involving the following: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse; or
 - (c) makes a misstatement or omission on an application form; or
 - (d) remains absent on leave for longer than one year, unless an extension is granted.

- (2) Administrative relinquishment will take effect immediately upon actual or special notice to the individual and will continue until the matter is resolved, if applicable.

7.D. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

- (1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Hospital, the President of the Medical Staff, the relevant department chief, the Chief Medical Officer, the Medical Executive Committee, or the Board chairperson is authorized to (1) suspend or restrict all or any portion of an individual's clinical privileges or (2) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed.
- (2) A precautionary suspension is effective immediately and will be promptly reported to the President of the Hospital and the President of the Medical Staff. A precautionary suspension will remain in effect unless it is modified by the President of the Hospital or the Board.
- (3) The individual will be provided a brief written description of the reason(s) for the precautionary suspension.
- (4) The Medical Executive Committee will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.
- (5) Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee.

7.E. INDICATIONS AND PROCESS FOR PROFESSIONAL REVIEW ACTIONS

Following an investigation, the Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges, or other actions, based on concerns about (a) clinical competence or practice; (b) the safety or proper care being provided to patient(s); (c) known or suspected violation of ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital, undermines the Hospital's culture of safety, or is disruptive to the orderly operation of the Hospital, its Medical Staff.

7.F. HEARING AND APPEAL PROCESS

- (1) The President of the Hospital will schedule the hearing and provide the individual with notice of the hearing.

- (2) The hearing will begin as soon as practicable, but no sooner than 30 days after the date of the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.
- (3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.
- (4) A Hearing Panel or Hearing Officer will be appointed.
- (5) A stenographic reporter will be present to make a record of the hearing.
- (6) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness; (d) to have representation by counsel who may be present and may call, examine, and cross-examine witnesses and/or present the case; (e) to submit a written statement at the close of the hearing; and (f) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.
- (7) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (8) The Hearing Panel may question witnesses, request the presence of additional witnesses, and request documentary evidence.
- (9) The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel to the President of the Hospital.

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

- (1) Amendments to these Bylaws may be proposed by a petition signed by 20% of the voting members of the Medical Staff, by the Bylaws Committee, or by the Medical Executive Committee.
- (2) Proposed amendments must be reviewed by the Bylaws Committee and Medical Executive Committee prior to a vote by the Medical Staff.
- (3) In the discretion of the Medical Executive Committee, amendments to the Bylaws may be made in one of the following ways:

(a) Meeting:

The Medical Executive Committee may present proposed amendments, including amendments proposed by the voting members as set forth above, at a regular meeting of the Medical Staff or at a special meeting called for such purpose. The Medical Executive Committee may also report, either favorably or unfavorably, on the proposed amendments. To be adopted, (i) the voting members must be provided with notice of the amendment, at least 30 days prior to the meeting; (ii) a quorum of at least 25% of the voting members must be present; and (iii) the amendment must receive a majority of the votes cast by the voting members.

(b) Written or Electronic Ballot:

The Medical Executive Committee may present proposed amendments, including amendments proposed by the voting members as set forth above, to the voting members, by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. The Medical Executive Committee may also report, either favorably or unfavorably, on the proposed amendments. To be adopted, (i) the voting members must be provided with notice of the amendment, at least 30 days prior to the vote; (ii) the amendment must be voted on by at least 25% of the voting staff; and (iii) the amendment must receive a majority of the votes cast by the voting members.

- (4) The Medical Executive Committee will have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling, or other errors of grammar or expression.

- (5) Amendments will be effective only after approval by the Board.
- (6) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the President of the Hospital within two weeks after receipt of a request.
- (7) Neither the Medical Executive Committee, nor the Medical Staff, nor the Board can unilaterally amend these Bylaws.

8.B. OTHER MEDICAL STAFF DOCUMENTS

- (1) In addition to the Medical Staff Bylaws, there will be policies, procedures, and rules and regulations that are applicable to members and other individuals who have been granted clinical privileges.
- (2) An amendment to the Credentials Policy, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of any proposed amendments to these documents will be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member of the Medical Staff may submit written comments on the proposed amendments to the Medical Executive Committee. To be adopted, the amendment must receive a majority of the votes cast by the voting members of the Medical Executive Committee.
- (3) Amendments to the Credentials Policy, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations may also be proposed by a petition signed by at least 20% of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents will be provided to the Medical Executive Committee at least 14 days prior to being voted on by the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendment before it is forwarded to the Medical Staff for vote.
- (4) Other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.
- (5) The Medical Executive Committee and the Board will have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice

of the proposed amendments to the Medical Staff. Notice of provisionally adopted amendments will be provided to each member of the Medical Staff as soon as possible. The Medical Staff will have 30 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.

- (6) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.
- (7) Amendments to Medical Staff policies are to be distributed or otherwise made available to Medical Staff members and those otherwise holding clinical privileges, in a timely and effective manner.

8.C. CONFLICT MANAGEMENT PROCESS

- (1) When there is a conflict between the Medical Staff and the Medical Executive Committee, supported by a petition signed by 20% of the voting members of the Medical Staff, with regard to:
 - (a) a new Medical Staff Rule and Regulation proposed by the Medical Executive Committee or an amendment to an existing Rule and Regulation; or
 - (b) a new Medical Staff policy proposed by the Medical Executive Committee or an amendment to an existing policy,

a special meeting of the Medical Staff to discuss the conflict will be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the Rules and Regulations or policy at issue.
- (2) If the differences cannot be resolved at the meeting, the Medical Executive Committee will forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.
- (3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.
- (4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or

amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the President of the Hospital, who will forward the request for communication to the Board chairperson. The President of the Hospital will also provide notification to the Medical Executive Committee by informing the President of the Medical Staff of such exchanges. The Board chairperson will determine the manner and method of the Board's response to the Medical Staff member(s).

8.D. UNIFIED MEDICAL STAFF PROVISIONS

8.D.1. Bylaws, Policies, and Rules and Regulations of the Unified Medical Staff:

Upon approval of a unified Medical Staff structure, the Medical Staff will adopt bylaws, and related documents which:

- (a) take into account the unique circumstances of each participating hospital, including any significant differences in the patient populations that are served and the clinical services that are offered; and
- (b) address the localized needs and concerns of Medical Staff members at each of the participating hospitals.

The voting members of the Medical Staff will have an opportunity to meet at least twice a year, including at the general meetings of the Medical Staff, to discuss any needs or concerns expressed by members at each separately licensed hospital. Any such issues will be referred to and addressed by the Medical Executive Committee.

8.D.2. Opt-Out Procedures:

If a unified Medical Staff structure is approved, the voting members of the Medical Staff at any hospital may later vote to opt out of the unified Medical Staff. Initiation of a vote to opt out requires submission of a written petition signed by no less than 20% of the Active Staff to the Medical Staff Office. A vote to opt out may not be held sooner than two years from the date the Medical Staff voted to opt in to a unified Medical Staff structure, or two years from the most recent vote under this Section. Medical Staff members will be advised of their right to call a vote to opt out of the unified Medical Staff at least every two years.

ARTICLE 9

HISTORY AND PHYSICAL

- (a) Except as provided in (b) below, a complete medical history and physical examination must be performed and documented on the patient's chart within 24 hours after registration or inpatient admission (but in all cases prior to surgery or a procedure requiring anesthesia services), by an individual who has been granted privileges by the Hospital to perform histories and physicals. The history and physical must reflect a comprehensive current physical assessment.
- (b) If a history and physical has been performed within 30 days prior to admission by a physician or advanced practice clinician licensed to practice in the state, a legible copy of the history and physical may be used in the Hospital medical record. A documented plan of treatment should be included in the history and physical or the progress notes.
- (c) If the history and physical was completed within the 30-day period prior to admission or readmission, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after registration or inpatient admission, and prior to any procedure requiring anesthesia services. The update must be based on an examination of the patient and must reflect any changes in the patient's condition since the date of the original history and physical or must state that there have been no changes in the patient's condition. All updates must be timed, dated, and signed by an individual who has been granted privileges by the Hospital to perform histories and physicals.
- (d) When the history and physical examination is not recorded before surgery or a procedure requiring anesthesia or a potentially hazardous diagnostic procedure, the procedure will be cancelled unless the attending physician states in writing that an emergency situation exists or that any such delay would be detrimental to the patient.
- (e) For outpatient surgery, the history will include documentation of the indications and symptoms warranting the procedure, listing of the patient's current medications, any existing co-morbid conditions and previous surgeries, and social history or conditions which would have an impact on the patient's care upon discharge from the facility following the procedure.
- (f) For ambulatory or same day procedures, a short stay history and physical may be utilized. A short stay history and physical will document, at a minimum, the patient's chief complaint or reason for the procedure, relevant history of the present illness or injury, current clinical condition, general appearance, vital signs, and an assessment of the heart and lungs.

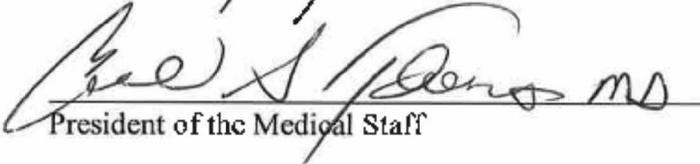
ARTICLE 10

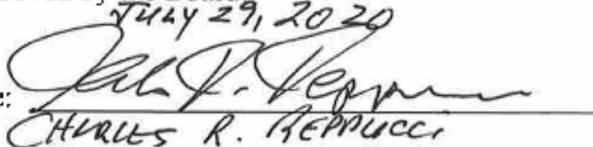
ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter contained herein.

The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rules and Regulations are inconsistent with these Bylaws, they are of no force or effect.

Adopted by the Medical Staff on:

Date: 7/29/20

President of the Medical Staff

Approved by the Board:
JULY 29, 2020
Date: 
CHARLES R. REPPUCCI

Chairperson, Board of Directors

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Senior Active	Affiliate	Courtesy	Consulting	Honorary	Advanced Practice Clinician with Privileges	Advanced Practice Clinician without Privileges
Patient Contacts	50 per 2 years OR 20 service hours	50 per 2 years OR 20 service hours	N	Less than 50 per 2 years	N	NA	50 per 2 years	NA
Exercise clinical privileges	Y	Y	N	Y	Y	N	Y	N
May attend meetings	Y	Y	Y	Y	Y	Y	Y	Y
Right to vote	Y	Y	P	P	P	P	Y	N
Serve as officer, department chief, division chief, or committee chairperson	Y	Y	Committee Chairperson only	Committee Chairperson only	Committee Chairperson only	Committee Chairperson only	Committee Chairperson only	N
Serve on committees	Y	Y	Y	Y	Y	Y	Y	N
Emergency call coverage	Y	May be excused	N	Y as requested	Y as requested	NA	NA	NA
Participate in/cooperate with professional practice evaluation and performance improvement processes	Y	Y	NA	Y	Y	N	Y	N
Pay application fees and dues	Y	Y	Y	Y	Y unless telemedicine practitioner	N	Y	Y

- Y = Yes
- N = No
- P = Partial (with respect to voting, only when appointed to a committee)
- NA = Not Applicable

Exhibit 44C



CREDENTIALING & PRIVILEGING

SUBJECT: Credentialing & Privileging	PREPARED BY: Lisa Swicker, CPCS, Manager, Medical Staff Services	EFFECTIVE DATE: 01/26/2021	POLICY NUMBER: WIH-MED-003
PAGE: 1 of 5	REVIEWED BY: Tolga Kokturk, MD, Immediate Past President of Medical Executive Committee	APPROVED BY: Robert Insoft, MD, Chief Medical Officer	REPLACES:

- I. **Purpose.** The purpose of this Credentialing & Privileging Policy is to provide a mechanism for credentialing and privileging professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and such policies as are adopted from time to time by the Board of Directors (Board).
- II. **Scope.** All Women & Infants Licensed Independent Practitioner’s and Allied Health Practitioners.
- III. **Policy.** It is the policy of Women & Infants Hospital that the credentialing and privileging of all Licensed Independent Practitioner’s (LIP’s) and Allied Health practitioners shall be done in accordance with the Medical Staff Bylaws and Rules and Regulations, Women & Infants Hospital Bylaws, and federal and state regulations, The Joint Commission, Center for Medicare and Medicaid (CMS) and this policy.
- IV. **Definitions.** None
- V. **Procedure.**

Applications for appointment may be obtained from the Medical Staff Office. The application shall contain a request for the specific membership status and clinical privileges desired by the applicant and require detailed information concerning the applicant's professional qualifications. An application shall be considered complete when all information is received from the primary source regarding the applicant’s training, experience, malpractice claims history since completion of training, current competence, RI licensure and controlled substance registrations, Federal DEA that includes a RI address, Board certification status, Government issued photo ID, proof of citizenship, background check, and any other information deemed necessary. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications. He/she shall have the burden of providing evidence that all statements made and information given on, or submitted with, the application are factual and true. Until the applicant has provided all requested information, the application will be deemed incomplete and will not be processed. The completed application, including all required supporting documentation, shall be submitted to the Medical Staff Office.

The Medical Staff Office personnel shall complete the primary source verifications, collect peer references, and all other information deemed pertinent (Attachment B). When this process is

completed, the Medical Staff Office will notify the appropriate Clinical Service Chief to review the applicant’s file. Upon completion of all reviews, the applicant’s file and any input from the Clinical Service Chief shall be forwarded to the Credentials Committee and Medical Executive Committee (MEC) for consideration.

The Committees shall examine evidence of the character, professional competence, qualifications, prior personal and professional behavior, and ethical standing of the applicant. They shall determine, through information contained in references given by the applicant and other sources, whether the applicant has established and meets all of the necessary qualifications for the staff category and clinical privileges requested. In addition, any current Medical Staff member shall have the right and responsibility to appear in person before the MEC to discuss confidentially any concerns he/she may have about the applicant.

The Credentials Committee and MEC shall send a recommendation regarding the applicant to the Board, through the Hospital President/COO or his/her designee. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and clinical judgment, references, and other relevant information. The applicant has the burden of establishing his/her qualifications for, and competence to, exercise the clinical privileges he/she requests.

The MEC shall transmit a written report to the Board, and its recommendation that:

1. The applicant be appointed with recommended privileges, or
2. The applicant be appointed with change in status and/or privileges requested, or
3. The applicant’s request be deferred pending additional information, or
4. The applicant is denied Medical Staff appointment and/or privileges.

The Chair of the MEC or his/her designee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

Upon receipt of a final recommendation from the MEC, the Board shall, after reviewing all pertinent information:

1. Approve Medical Staff appointment with recommended privileges, or
2. Approve Medical Staff appointment with change in status and/or privileges requested, or
3. Defer approval of Medical Staff appointment and/or privileges pending additional information, or
4. Deny Medical Staff appointment and privileges.

Other Credentialing Requirements:

Basic Life Support (BLS) certification

- All health care personnel
- WIH non-pediatric employed providers including staff Radiologists
- OB/GYN providers who cover residents

Advance Cardiac Life Support (ACLS) certification

- Anesthesia providers
- AMS, Endoscopy, LDR, PACU, Triage/ED nursing staff
- OB medicine providers
- Oncology providers
- OB/GYN residents
- OB/GYN ED/Triage physicians, and nurse practitioners
- Nursing supervisors
- Adult in-house nurse educators in designated clinical areas
- Adult in-house ANMs in designated clinical areas
- Endoscopy providers.

Pediatric Providers who are attending physicians in the Neonatal Intensive Care Unit are required to have current Neonatal Resuscitation Program (NRP) certification.

ID Badges – Photo Identification badges will be issued upon completion of the initial credentialing process and Board of Directors approval.

New applicants must bring their photo ID to the Medical Staff Office to verify the identity of the applicant in accordance with Joint Commission Standard MS.06.01.03, element #5.

A current copy of the photo ID badge is required in the Medical Staff Office for tracking purposes. Once every four (4) years, or every 2nd recredentialing cycle, whichever comes first, each provider will be required to be issued a new ID badge with a copy submitted to the Medical Staff Office to remain current.

Expedited Approval Process:

Pursuant to Bylaws, Article II, Section 7, “The organized medical staff may use an expedited approval process for appointments and reappointments to membership and/or granting of privileges or renewal or modification of privileges, provided the application meets criteria set forth in medical staff policy. Expedited credentialing is a Board of Directors function and when it is used, the Board of Directors delegate the authority to render expedited decisions outside of the full Board to an ad hoc committee of at least two voting members of the Board.”

Appointment to the Medical Staff shall be for a term of no longer than two years. In the event that, after receipt of a favorable recommendation from the MEC, the Board’s decision is unfavorable to the applicant, the applicant may be entitled to the hearing and appeal procedures set forth in Article IV before a final determination is made by the Board.

All appointments shall be to one of the following categories: Active, Consulting, Courtesy, Auxiliary, Honorary, or Allied Health Staff. Each individual appointed to the Medical or Allied Health Staff shall be entitled to exercise only those privileges specifically granted by the Board, except as stated in policies adopted by the Board.

Time Limited Privileges:

- A. Time limited privileges may be granted when a new applicant for Medical or AHP Staff appointment or privileges is waiting for a review and recommendation by the Medical Staff Executive Committee and approval by the Board of Directors. They may be granted for a limited period of time, not to exceed 120 days, upon recommendation of either the applicable clinical department chief or the President of the Medical Staff, provided:
- There is primary source verification of current licensure, RI Federal DEA, relevant training or experience, current competence, ability to perform the privileges requested, proof of minimum malpractice coverage and claims history;
 - The results of the National Practitioner Data Bank (NPDB) query have been obtained and evaluated; and
 - The applicant has a complete application; has no current or previously successful challenge to licensure or registration, has not been subject to involuntary termination of medical staff membership at another organization, and has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

- B. Time limited privileges may be granted on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Examples would include, but are not limited to:
- A situation where a Medical or Allied Health Professional (AHP) Staff appointee becomes ill or takes a leave of absence and a physician or AHP would need to cover the practice until the Medical or AHP Staff appointee returns; or
 - A specific physician or AHP has the necessary skills to provide care to a patient that a Medical or AHP Staff appointee currently privileged does not possess; or
 - A visiting physician or surgeon who requests time limited privileges in accordance with RIGL 5-37-14 and its interpretation, that the Board of Medical Licensure will not discriminate against legally qualified physicians of another state who have not opened an office or have been appointed in any place in this state where they may meet patients or receive calls, and are called to see a particular case under the license of a physician privileged at Women & Infants Hospital. The RI Board of Medical Licensure would expect compliance with all RI immunization requirements.
 - Time limited Privileges shall not exceed three (3) times in one year for the same provider. After three occurrences of time limited privileges, the provider must apply for full privileges to the Medical Staff.

In these circumstances, time limited privileges may be granted upon recommendation of either the applicable clinical department chief or the President of the Medical Staff provided there is primary source verification of:

- Current licensure; and
 - Current competence.
- C. In exercising time limited privileges, the physician or AHP shall follow the Bylaws and policies of the Hospital and act under the supervision of the appropriate department chief or his or her designee. Special requirements of supervision and reporting may be imposed by the appropriate department chief on any physician or AHP granted time limited privileges. The granting of time limited privileges does not imply in any way that full privileges will be granted.
- D. Administration may at any time, upon the recommendation of either the appropriate department chief or President of the Medical Staff, terminate a physician's or AHP's time limited privileges effective as of the discharge from the Hospital of the physician's or AHP's patient(s) then under his or her care in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the physician or AHP, the termination may be imposed by any person entitled to impose a time limited suspension, and the same shall be immediately effective. The appropriate department chief, or in his or her absence the President of the Medical Staff, shall assign an appointee of the Medical or AHP Staff to assume responsibility for the care of such terminated physician's or AHP's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute Medical or AHP Staff appointee. Termination of time limited privileges shall not afford the physician or AHP affected any procedural or other rights under Article IV of these Medical Staff Association

Time Limited Privileges under Preceptorship:

Persons requesting time limited privileges for no longer than 120 days, the sole purpose of being preceptored for specific procedure(s), may be granted by completing the following process:

Requirements:

Letter from the applicant requesting the privileges;
Completion of the Time Limited Privilege application;
Identification of the Preceptor responsible to supervise the training and agreement to proctor;
Length of time for privileges identified (no longer than 120 days);
Approval by the Department Chair;
Copies of current CV, license(s), DEA, malpractice insurance;
One Peer Reference;
Proof of Identity;
AMA Profile;
OIG and Systems Access Management (SAM) query, Data Bank query, Local RI court check;
Board Certification Query;
Signed HIPAA, Medicare Acknowledgement, Health Status Questionnaire;
The applicant must meet RI Department of Health immunization requirements; Licensure query for disciplinary actions/reprimands

Upon receipt of the requested documentation, primary source verification shall be completed for all licenses, Board Certification, OIG, SAM, National Practitioner Data Bank, AMA Profile, immunization status, and peer reference.

When the provider is not licensed in the State of Rhode Island, the Medical Staff Office will check with Medical Board regarding licensure requirements for out of state trainees and length of time they may come for training and be preceptored. Upon completion of the time limited privileges request, the privileges will be forwarded to the Department Chief for approval, followed by the President and COO or his/her designee.

The above policy also applies regarding reappointment applications except that numbers A. B. and D. do not apply. In addition to the above, documentation of continuing medical education in specialty and proof of current re-certification in specialty or subspecialty within two examination cycles after expiration of a time limited certificate will be required to retain appointment and clinical privileges.

Attachment A: Credentialing & Privileging Process

Attachment B: Primary Source Verification

REFERENCES:

JC Standard #: MS.01.01.01, .06.01.03, .06.01.09

APPROVAL/REVISION:

DATE: Initial Version of Policy approved by: Credentials Committee, 8/04/2010; Medical Executive Committee, 8/10/2010; Board of Trustees 08/24/2010

DATE: Revision approved by Credentials Committee 07/03/2012; Medical Executive Committee 07/10/2012; Board of Directors: 07/26/2012

DATE: Revision approved by Credentials Committee 12/17/2015; Medical Executive Committee 12/17/2015; CNE Credentials Committee, 12/17/2015; Board of Directors: 12/17/2015

DATE: Reviewed by Credentials Committee 01/13/2021; Medical Executive Committee 01/14/2021

REPLACES: N/A

CONFIDENTIAL

CONFIDENTIAL

C-R-CNE-LS44-0076702

CONFIDENTIAL
**WOMEN & INFANTS HOSPITAL
MEDICAL STAFF ASSOCIATION BYLAWS**

Adopted: July 22, 2003
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Revised: March 22, 2012
Revised: January 10, 2013
Revised: March 27, 2014
Revised: March 22, 2018
Revised: September 27, 2019

CONFIDENTIAL
**WOMEN & INFANTS HOSPITAL
MEDICAL STAFF ASSOCIATION BYLAWS**

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INTRODUCTION

The Medical Staff Association of Women & Infants Hospital of Rhode Island (the "Hospital"), is an extension of the Board of Directors and established, as directed by the Hospital Bylaws for the purpose of carrying out necessary educational, research, and quality control functions, and providing oversight for the quality of care, treatment and services provided.

For the purpose of these Bylaws the following terms shall have the following meanings:

"Medical Staff" means all Active, Auxiliary, Courtesy, Consulting, Honorary, Per Diem and AHP Staff appointees, as further defined in Article III hereof.

"House Staff" means all residents and fellows under contract with the Hospital.

"AHP" means Allied Health Professional, as further defined in Article III, Section 6 hereof.

"Admitting Physician" means the Medical Staff appointee who admits or authorizes admission of a patient as provided under applicable Hospital policies. As of a given point in time the Admitting Physician may also be the Attending Physician.

"Attending Physician" means the Medical Staff appointee responsible for the care of a patient as of a given point in time as provided under applicable Hospital policies. As of a given point in time the Attending Physician may also be the Admitting Physician.

"Administration" means the President and Chief Operating Officer of the Hospital or his or her designee.

**ARTICLE I
NAME**

The name of this organization shall be the "Medical Staff Association of Women & Infants Hospital of Rhode Island".

**ARTICLE II
APPOINTMENT AND/OR CLINICAL PRIVILEGES**

Section 1. Qualifications

The applicant for Medical Staff appointment and/or clinical privileges shall be an MD or DO licensed or legally authorized to practice medicine in the State of Rhode Island and shall maintain medical liability insurance in an amount and type as recommended by the Medical Staff Executive Committee and approved by the Board of Directors. Dentists and oral surgeons applying for Consulting Staff appointment and or clinical privileges shall be appropriately licensed by the State of Rhode Island.

Any applicant for Medical staff appointment or reappointment at the Active or Courtesy level must, at a minimum, be enrolled, if not fully credentialed, in good standing in all appropriate state/federal Medicare/Medicaid and other federal health care programs.

Any applicant for Medical Staff appointment and/or clinical privileges who has been terminated, excluded or precluded by government action from participation in Medicare, Medicaid or any other federal health care program shall be ineligible for appointment, clinical privileges, or reappointment until such time as the applicant is fully eligible to participate in Medicare, Medicaid and all other federal health care

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programs. In addition, any termination, exclusion or preclusion of an appointee of the Medical Staff by government action from participation in Medicare, Medicaid or any other federal health care program occurring during the term of any appointment to the Medical Staff shall automatically result in the suspension of such appointee from the Medical Staff and the suspension of all clinical privileges for such appointee and in the event that such appointee's participation is not fully reinstated by the expiration of the current appointment term, such appointee will be deemed to have resigned from the Medical Staff at that time. Such suspension shall not entitle the appointee to any hearing or appeals process in Article IV of the Medical Staff Association Bylaws.

Physicians and AHPs employed by the Hospital either full or part-time whose duties include clinical responsibilities and functions involving their professional capability, must also meet these standards and requirements.

Only physicians (and dentists or oral surgeons with respect to the Consulting Staff) and AHPs who can document their background, experience, training, and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and the Board of Directors that any patient treated by them in the Hospital will be given a high quality of medical care, shall be qualified for Medical Staff appointment and/or clinical privileges. **Applicants must also meet board certification and/or maintenance of Certification (MOC) eligibility requirements set forth in the departmental rules and regulations.** Applicants meeting the above criteria shall not be denied Staff appointment and/or clinical privileges on the basis of sex, race, creed, color, or national origin, or on the basis of physical or mental impairment if otherwise qualified, or on the basis of any criterion other than professional and ethical justifications. No physician (or dentist or oral surgeon with respect to the Consulting Staff) shall be entitled to appointment on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice, in this or any other state, or that he or she is a member of any professional organization or that he or she had in the past or presently has such privileges at another hospital.

Where physicians are being considered for appointment to the Active Staff, special consideration shall be given to evaluation of an applicant's special skills, training, and abilities in light of the Hospital's present and future needs. Before a privilege can be created consideration must be given to the availability of resources to support the new privilege.

Conviction of any Medical Staff appointee for any felony or misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, Medicare, Medicaid, or medical insurance fraud or abuse, or a plea of guilty to charges pertaining to the foregoing, shall result in automatic termination of Medical Staff appointment and/or clinical privileges. A plea of nolo contendere to charges pertaining to the foregoing may result in termination of Medical Staff appointment and/or all clinical privileges in accordance with Article IV of these Medical Staff Association Bylaws. Any Medical Staff appointee whose Medical Staff appointment and/or clinical privileges have been terminated in accordance with the foregoing may apply for reinstatement, but such appointee shall not be entitled as a matter of right to any such reinstatement of appointment and/or privileges.

Any expiration, revocation or suspension of a Medical Staff appointee's Rhode Island professional license will automatically result in the suspension of Medical Staff appointment and all clinical privileges until such time as such appointee's Rhode Island professional license has been renewed or restored in full. In the event that an appointee's Rhode Island professional license is restricted in part, the clinical privileges that would be affected by such restriction will automatically be similarly restricted. Any revocation, limitation or suspension of a Medical Staff appointee's federal or state controlled substance registration will automatically result in the suspension of the right of such appointee to prescribe medications in the Hospital to the extent covered by such revocation, limitation or suspension, until such time as such

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appointee's registration has been renewed or restored in full. However, if any expiration, revocation, suspension, or limitation of the appointee's Rhode Island professional license or state or federal controlled substance registration was based on anything other than merely administrative reasons, the lifting of the action taken shall not be automatic but shall be subject to prior review and approval by the Medical Staff Executive Committee and may be subject to the imposition of one or more conditions imposed as a result of such review.

Licensed Providers in good standing in the state of Rhode Island and/or Massachusetts who have current malpractice coverage and who only provide outpatient non-oncologic chemotherapy treatments for their patients at one of the Hospital operated Infusions Centers do not need to be credentialed members of the Medical Staff. However, they must be licensed in the state the patient is being referred, abide by all medical, nursing and pharmacy policies of the Infusion Centers as overseen by the centers respective leadership teams, as well as abide by any restrictions to treatments set forth in the approved Hospital drug formularies.

Section 2. Ethics and Ethical Relationships

Generally accepted ethical standards applicable to their profession shall govern the professional conduct of appointees on the Medical Staff. Specifically, all appointees of the Medical Staff shall pledge themselves that they will not receive from or pay to another health care provider, either directly or indirectly, any part of a fee received for professional services unless such services are actually rendered.

Section 3. Application for Appointment and/or Clinical Privileges

- A. Application for Medical Staff appointment and/or clinical privileges shall be presented on a form prescribed by the Hospital, documenting education, work experience, training, skill, licenses, certificates, good judgment, current competency, and ability to work with others. Such documentation shall also include R.I. License number, Narcotic numbers (if applicable), past and present hospital affiliations, past practice, **immunization compliance as required by the State of Rhode Island for Healthcare Workers**, type and amount of medical liability insurance, any malpractice action, or disciplinary action by any federal agency, state agency, county society or hospital. The application shall also require the applicant to list Board Certification - admissibility, **or Maintenance of Certification (MOC) and the name of three (3) references** who can speak to his or her clinical ability and professional performance, and a statement of privileges sought. The applicant should also list whether professional or drug licenses, past or present hospital affiliations or privileges have been limited, denied, revoked, suspended, reduced, not renewed, voluntarily or involuntarily relinquished or there have been convictions of any violations of the law. A copy of the Medical Staff Association and the Hospital's Bylaws, and departmental rules & regulations relating to applicant's specialty shall accompany the applications given to the applicant and the application form shall contain a statement that he or she has read and agrees to abide by such Medical Staff Association Bylaws, **Credentialing Policies**, and department rules and regulations, **Policies and Procedures of the Hospital and Governance System** as amended. upon granting of his or her Medical Staff appointment.
- B. An applicant for appointment and/or clinical privileges has the duty to provide current updated information that is relevant to **all** questions on the application form, even after the application has been completed. Any misrepresentation, misstatement, or omission from the application is cause for termination of the application process.
- C. By applying for Medical Staff appointment and/or clinical privileges, each applicant thereby: (i) signifies his or her willingness to appear for an interview regarding his or her application; (ii) authorizes the Hospital to consult with appointees of medical staffs of other hospitals with which the

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applicant has been associated and with others who may have information bearing on his or her current clinical competence, character, and ethical qualifications; (iii) consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his or her current clinical competence to carry out the clinical privileges he or she requests as well as of his or her moral and ethical qualifications for Medical Staff appointment; (iv) authorizes the Hospital to conduct a criminal background and social security investigation; (v) releases from any liability all representatives of the Hospital and its Medical Staff from their acts performed in good faith in connection with evaluating the applicant and his or her credentials; and (vi) releases from any liability all individuals and organizations who provide information to the Hospital in good faith concerning the applicant's current clinical competence, ethics, character, and other qualifications for Medical Staff appointment and clinical privileges, including otherwise privileged or confidential information to the extent that such releases are permitted by law.

Section 4. Procedures for Appointment and/or Clinical Privileges

- A. The completed application for a Medical Staff initial appointment and/or clinical privileges shall be presented to Administration, who upon completion of primary verification, shall forward it to the appropriate department chief.
- B. The department chief shall forward the application, including information regarding the applicant's medical clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism, to the Credentials Committee with his or her written recommendations. If the recommendation is favorable, the chief should denote staff category and/or clinical privileges; if the recommendation is not favorable, the chief must indicate the reasons.
- C. The Credentials Committee shall review the character, qualifications, and standing of the applicant. This review shall be at the discretion of the Chair by this Committee as a whole or a designated member or members thereof. The Credentials Committee shall submit a report of its findings and recommendations as to whether the applicant is qualified for the recommended staff category and/or clinical privileges to the Medical Staff Executive Committee as soon as possible. It may recommend that the application be accepted, deferred, or rejected, and must indicate its reasons if deferred or rejected. When a recommendation is made by the Credentials Committee to defer, it must be followed by one to accept or reject the application at its next scheduled meeting, if it has had reasonable opportunity to obtain the necessary information.

If the Medical Staff Executive Committee concurs with the recommendation of the Credentials Committee that an appointment and/or clinical privileges are warranted by the qualifications of the applicant, it shall submit its recommendations of staff category and/or clinical privileges to the Board of Directors, as soon as possible. It may recommend that the application be accepted, deferred, or rejected, and must indicate its reasons if deferred or rejected. When a recommendation is made by the Medical Staff Executive Committee to defer, it must be followed by one to accept or reject the application at its next scheduled meeting, if it has had reasonable opportunity to obtain the necessary information. Completed applications should be processed through the Board of Directors within one hundred twenty (120) days, if there has been reasonable opportunity to process same.

- D. Notwithstanding Article II, Section 3.A, above, the Medical Executive Committee, upon the recommendation of the department chief, may waive the requirement for Board Certification or admissibility in extraordinary circumstances for applicants with unique qualifications, and the Hospital's need for the applicant's specialty.

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- E. Final action of the Board of Directors shall be transmitted by Administration to the applicant, with copies to the Chairs of the Executive and Credentials Committees and the chief of the appropriate department. If the Board of Directors determines to deny initial Medical Staff appointment and/or clinical privileges to an applicant, other than for reasons set forth in Article IV, Section 7 hereof, such applicant may initiate procedures as provided in Article IV, Section 6 hereof only. An individual denied appointment and/or clinical privileges may not apply for Medical Staff appointment and/or clinical privileges for a period of five (5) years unless the Board of Directors provides otherwise.

Section 5. Procedures for Changes in Status and Leaves of Absence

- A. All requests for changes in status, including leaves of absence and resignations, shall be submitted in writing to the appropriate department chief **with a copy to the Medical Staff Office**
- B. Every request for a leave of absence shall state the reason and duration of the leave of absence.
- C. After review by the department chief, he or she will submit his or her recommendation to the Credentials Committee. The Credentials Committee shall submit its final recommendation to the Medical Staff Executive Committee and the Medical Staff Executive Committee shall submit its final recommendation to the Board of Directors following the same time table as required for new applicants. After final action by the Board of Directors, the Medical Staff appointee shall be notified by Administration of the outcome of his or her request.
- D. A leave of absence shall not exceed one year. Upon recommendation by the department chief, Credentials and Medical Staff Executive Committees, and approval of the Board of Directors one one-year extension to the leave may be made. After a two-year leave of absence, reapplication for Medical Staff appointment and/or clinical privileges is **required or the member's privileges and membership will be considered voluntarily resigned**
- E. A Medical Staff appointee on leave of absence shall be precluded from attending patients in the Hospital unless otherwise specified in the approval of the Board of Directors. While an appointee is on leave of absence, his or her appointment and/or clinical privileges rights and responsibilities shall be inactive, but the obligation to complete **a reappointment application if the reappointment falls within the leave of absence timeframe, and completing** medical records shall continue unless expressly waived by the Medical Staff Executive Committee.
- F. In order to have appointment and/or clinical privileges reinstated, a Medical Staff appointee shall submit a written request to the appropriate department chief **with a copy to the Medical Staff Office**. Such request must include evidence of activities during the leave of absence along with copies of current Professional License, State and Federal Drug Licensure (if held), and malpractice policy with proof of type and amount of liability limits as recommended by the Medical Staff Executive Committee and approved by the Board of Directors. In the case of a leave of absence for health reasons, pertinent information substantiating that the appointee has recovered sufficiently to resume the practice of medicine with or without all reasonable accommodations must also be submitted. The department chief shall, based upon the appointee's health status, with the option of asking for a second medical opinion, current clinical competence or other relevant criteria, determine if, when and to what extent the appointee's appointment and/or clinical privileges can be reinstated. In the case of a leave of absence for other than health reasons, the department chief shall, based upon documentation of current and competent clinical performance and/or other relevant criteria, determine if, when and to what extent the appointee's appointment and/or clinical privileges can be reinstated. The request for reinstatement shall be processed in accordance with Paragraph C above.

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- G. Failure without good cause to request reinstatement or extension within one year of the initiation of the leave of absence, or to request reinstatement at least sixty (60) days prior to the expiration of any extended leave of absence, shall be deemed a voluntary resignation from the Medical Staff and Administration shall notify the member of the Medical Staff concerned. The **Medical Staff Member** affected may reapply for Medical Staff appointment and/or clinical privileges, and if approved, the Medical Staff member shall be subject to a focused review in accordance with Article II, Section 8.

Section 6. Procedures for Reappointment and/or Continuation of Clinical Privileges

- A. Members of the Medical Staff will be sent a reappointment application no later than four (4) months prior to the expiration of their current appointment. The application shall be completed in its entirety and returned to the Medical Staff Office within thirty (30) days, along with supporting documentation and updated information, as necessary. Applicants who do not return the reappointment application within the thirty (30) day period will be notified in accordance with the notice procedures set forth in Article IV, Section 8, indicating that non-compliance with this procedure may result in loss of the current appointment and/or clinical privileges, and that this action is not subject to any hearing and appellate review procedures set forth in these Medical Staff Bylaws.
- B. The Medical Staff Office will review the application for completeness, conduct primary verification, and gather any additional information from external sources that are needed to complete the application process. External sources shall include, but not be limited to:
- Query of all current hospital verifications;
 - Evidence of activity and procedures from other facilities for low volume providers;
 - Peer references;
 - Claims history information; and
 - Primary source verification of all licenses and disciplinary actions.

Once the application is complete, the application will be reviewed by the department chair, who shall make recommendation on the reappointment application and/or clinical privileges.

In order for a member of the Medical Staff to retain his or her right to request reappointment and/or clinical privileges he or she must:

- Hold a current R.I. License;
- Maintain medical liability insurance coverage in an amount and type as recommended by the Medical Staff Executive Committee and approved by the Board of Directors; and
- Become Board Certified within a time period to be determined by the appropriate department or provide evidence of current re-certification in specialty or subspecialty within one year after expiration of a time limited certificate. **Members of the Medical Staff are also required to maintain their Board Certification annual requirements if warranted.** At the discretion of the appropriate department chief, extension of the re-certification requirement may be granted. In addition, board certification may be waived by the Medical Executive Committee in accordance with Article II, Section 4.D.

The Credentials Committee shall review information supplied by the appropriate department chief for each appointee of the Medical Staff. Such review shall be for the purpose of determining whether he or she shall be reappointed to the Medical Staff and with what clinical privileges. The department chief shall submit his or her evaluation on a form approved by the Credentials Committee. This evaluation will include appraisal, since last appointment or reappointment, of the appointee's:

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- Performance information based at least in part on the findings of quality improvement measures reflecting current competency, medical clinical knowledge, clinical judgment, technical and clinical skills, mental and physical stability, and interpersonal and communication skills and professionalism, including relationships with other physicians, dentists, oral surgeons, AHPs, Hospital employees, and patients;
 - Current privileges and the basis for any requested modifications;
 - Adverse final judgments or settlements of medical liability litigation;
 - Limited, denied, revoked, suspended, reduced, not renewed, voluntary or involuntary relinquishment of professional or drug licenses, past or present Hospital affiliations or privileges;
 - Health status, including submitting to a physical examination by a physician approved by the department chief or Medical Staff Executive Committee if this is deemed necessary;
 - Participation in continuing medical education (verified by proof of current medical licensure which requires continuing medical education credits for renewal in accordance with State law) (Note: appointee attests to number of CME hours within specialty earned on reappointment application; copies of the CME Certificate must be produced if requested);
 - Verification of license(s);
 - Timely completion of medical records; and
 - Compliance with Hospital policies and the Medical Staff Bylaws.
- C. The Credentials Committee shall present its report at the next regularly-scheduled meeting of the Medical Staff Executive Committee recommending reappointment and/or clinical privileges or non-reappointment of each appointee. The report shall specify the particular staff category and clinical privileges to be granted each Medical Staff appointee or the reason for non-reappointment or restriction.
- D. The Medical Staff Executive Committee shall make its report to at the next regularly-scheduled meeting of the Board of Directors, recommending reappointment and/or clinical privileges or non-reappointment of each appointee. The report shall specify the particular staff category and clinical privileges to be granted each Medical Staff appointee or the reason for non-reappointment or restriction.
- E. Final action of the Board of Directors of the Hospital shall be transmitted by Administration with copies to the Chairs of the Medical Staff Executive and Credentials Committees and the chief of the appropriate department. Failure of the Medical Staff appointee to timely return a signed reappointment form may be grounds for loss of appointment. An appointee must be notified, in the manner provided in Article IV, Section 8 hereof, one week prior to loss of Medical Staff appointment.

Loss of appointment for failure to return the reappointment form shall not be subject to the hearing and appellate review procedures in Article IV of these Medical Staff Association Bylaws. Reinstatement shall be on such terms as the Credentials Committee may determine.

Section 7. Expedited Approval Process

The Medical Staff Association may use an expedited approval process for appointments and reappointments to Medical Staff and/or granting of privileges or renewal or modification of privileges, provided the application meets criteria set forth in Medical Staff policy. Expedited credentialing is a Board of Directors function and when used, the Board of Directors delegates the authority to render expedited decisions outside of the full Board to an ad hoc committee of at least two voting members of

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the Board. Applications will be processed with equal standards only after the Medical Staff Office has obtained a completed, verified application that meet predefined, Board-approved criteria.

Section 8. Terms of Appointment

- A. All appointments and reappointments shall be made by the Board of Directors, upon the recommendation of the Medical Staff Executive Committee for a period of not more than two (2) years, with the exception of Honorary Staff. Appointments to the Medical Staff shall confer on the appointee only such privileges as may be specified in the notice of appointment in accordance with these Medical Staff Association Bylaws.
- B. A practitioner providing clinical services at the Hospital may exercise only those privileges granted by the Board of Directors or emergency and disaster privileges as described herein. Privileges may be granted by the Board of Directors upon recommendation of the Medical Staff Executive Committee to practitioners who are not Medical Staff appointees. Such individuals may be Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), physicians serving short locum tenens positions, telemedicine physicians or others deemed appropriate by the Medical Staff Executive Committee and the Board of Directors.

Section 9. Focused Professional Practice Evaluation (FPPE)

- A. All initially requested privileges **will be granted under provisional status and** shall be subject to a 6-month period of focused professional practice evaluation (FPPE). **One 6-month extension may be considered by the Board. No initial FPPE shall exceed one year.** Failure to complete the FPPE within the given timeframe will result in a voluntary resignation of privileges. The applicant will be eligible to re-apply for initial appointment. The Credentials Committee, after receiving a recommendation from the department chair and with the approval of the Medical Staff Executive Committee, will define the circumstances which require monitoring and evaluation of the clinical performance of each member of the Medical Staff following his or her initial grant of clinical privileges at the Hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review; the tracking of performance monitors/indicators; external peer review; simulations; morbidity and mortality reviews; and discussion with other healthcare individuals involved in the care of the patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.
- B. The Medical Staff will also engage in ongoing professional practice evaluation (OPPE) to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of current clinical competency of a member of the Medical Staff. In addition, each member of the Medical Staff may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of current clinical competence, practice behavior, and ability to perform a specific privilege of a member of the Medical Staff.

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Section 10. Fees

Initial and reappointment fees will be charged to all applicants for Medical Staff appointment. Such fees will be set by Credentials Committee policy approved by the Medical Staff Executive Committee. **If reappointment applications are not returned within 30 days of being sent, a surcharge of \$50 may be applied.**

Section 11. Temporary Privileges

A. Temporary privileges may be granted when a new applicant for Medical Staff appointment or privileges is waiting for a review and recommendation by the Medical Staff Executive Committee and approval by the Board of Directors. They may be granted for a limited period of time, not to exceed 120 days, by Administration upon recommendation of the applicable clinical department chief **and** the President of the Medical Staff, provided:

- There is primary source verification of current licensure, relevant training or experience, current competence, ability to perform the privileges requested, proof of minimum malpractice coverage;
- The results of the National Practitioner Data Bank query have been obtained and evaluated; and
- The applicant has a complete application; has no current or previously successful challenge to licensure or registration, has not been subject to involuntary termination of Medical Staff membership at another organization, and has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

B. Temporary privileges can be granted on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Examples would include, but are not limited to:

- A situation where a Medical Staff appointee becomes ill or takes a leave of absence and a physician or AHP would need to cover the practice until the Medical Staff appointee returns; or
- A specific physician or AHP has the necessary skills to provide care to a patient that a Medical Staff appointee currently privileged does not possess.

In these circumstances, temporary privileges may be granted by Administration upon recommendation of the applicable clinical department chief **and** the President of the Medical Staff provided there is primary source verification of:

- Current licensure; and
- Current competence.

C. In exercising temporary privileges, the physician or AHP shall follow the Bylaws and policies of the Hospital and act under the supervision of the appropriate department chief or his or her designee. Special requirements of supervision and reporting may be imposed by the appropriate department chief on any physician or AHP granted temporary privileges. The granting of temporary privileges does not imply in any way that full privileges will be granted.

D. Administration may at any time, upon the recommendation of either the appropriate department chief or President of the Medical Staff, terminate a physician's or AHP's temporary privileges effective as of the discharge from the Hospital of the physician's or AHP's patient(s) then under his or her care in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the physician or AHP, the termination may be imposed by any person entitled to impose a temporary suspension, and the same shall be immediately effective. The

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appropriate department chief, or in his or her absence the President of the Medical Staff, shall assign an appointee of the Medical Staff to assume responsibility for the care of such terminated physician's or AHP's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute Medical Staff appointee. Termination of temporary privileges shall not afford the physician, dentist, oral surgeon or AHP affected any procedural or other rights under Article IV of these Medical Staff Association Bylaws.

Section 12. Emergency Privileges

In the case of emergency, any physician or AHP appointee of the Medical Staff shall be permitted and assisted to do everything possible to save the life of a patient, using every necessary facility of the Hospital, including the calling for any consultation necessary or desirable. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

When the welfare of a patient is such that consultation and/or treatment of that patient should be obtained from a physician or AHP not presently an appointee of the Medical Staff, but who has the skills or training necessary for the care of the patient, Administration, upon the recommendation of the appropriate department chief or his or her designee, may grant emergency privileges to such physician or AHP for the duration of that patient's hospitalization. The physician or AHP shall work in conjunction with the Admitting Physician.

The Medical Staff Office shall verify such emergency privileges as soon as possible by obtaining: (i) the name of the physician or AHP granted emergency privileges; (ii) proof of current licensure; (iii) malpractice insurance; and, (iv), a photo ID for the purpose of doing a criminal background and social security investigation. The Office of Inspector General (OIG) and National Practitioner Data Bank (NPDB) will also be queried. Emergency privileges shall automatically expire and have no further effect upon discharge of the patient being treated from the Hospital. Emergency privileges may be revoked at any time for any reason by Administration or the department chief, or their designee. Denial, revocation or expiration of emergency privileges shall not be subject to the hearing and appellate process provided in Article IV of these Medical Staff Association Bylaws.

Section 13. Disaster Privileges

Disaster privileges may be granted to a volunteer physician or AHP by Administration or the President of the Medical Staff or his or her designee when the Hospital's Disaster Plan has been activated and the Hospital is unable to handle the immediate patient needs.

Before granting Disaster Privileges, the physician or AHP must present a valid government-issued photo identification issued by a State or Federal Agency (e.g., Driver's License or Passport) and at least one of the following:

- Current picture Hospital ID card with professional designation;
- Current license to practice or primary source verification of license by the Medical Staff Office;
or
- Identification indicating the physician or AHP has been granted authority to render patient care, treatment, and services during disaster or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized Federal, State, or Municipal organization or group.

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In the absence of one of the three forms of verification noted above, a current Hospital Employee or Medical Staff appointee with personal knowledge of ability to act as a physician or AHP during a disaster may attest to the identity of the physician or AHP.

The Medical Staff Office will attempt to verify licensure upon request for Disaster Privileges. Should this not be possible, verification will occur as soon as practicable after the immediate situation is under control and, except in extraordinary circumstances, will be completed within 72 hours from the time when the volunteer physician or AHP presents to the organization. The time the privileges were granted will be documented, and Administration will make a decision within 72 hours regarding whether to continue the privileges.

Once the decision has been made to grant disaster privileges, the Security Office will provide the practitioner with a hospital identification badge. Patient care, treatment, and services provided by physicians or AHPs who have been granted disaster privileges will be monitored by the physician manager or designee of the department in which services are provided via direct observation.

Disaster Privileges shall automatically terminate once the state of emergency no longer exists or when the physician or AHP's services are no longer required, as determined by Administration. Disaster privileges may be revoked at any time. The termination of Disaster Privileges shall be final and shall not be subject to the hearing and appellate review procedures under Article IV or these Medical Staff Association Bylaws.

**ARTICLE III
CATEGORIES OF THE MEDICAL STAFF**

Section 1. The Medical Staff

The Medical Staff shall be divided into Active, AHP, Auxiliary, Courtesy, Consulting, Honorary and Per Diem Staff.

Certain categories of AHPs shall be subject to supervision of the appointees of the Medical Staff as set forth in Article III, Section 6.

The House Staff are not Medical Staff appointees. They are required to adhere to these Medical Staff Association Bylaws and shall be supervised by the chief of their appropriate department or his or her designee.

Fellows may, with written approval of their respective program directors, apply for moonlighting privileges in accordance with Hospital policy for moonlighting fellows.

Section 2. The Active Staff

A. The Active Staff shall include those physicians with privileges to admit, attend, and participate in the care of patients in the Hospital, and who have been selected because of their interest in the work of the Hospital. Appointees of the Active Staff shall be required to have satisfactorily completed an approved residency in their respective specialty. They shall attend inpatients assigned to them, render care to outpatients in their respective fields and where appropriate, provide emergency service, care and consultation, as assigned. Appointment on the Active Staff may be held by appointees in Active and Consulting Clinical Departments.

B. Appointees of the Active Staff shall be eligible to vote and hold office.

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- C. Appointees of the Active Staff shall be assigned to clinical departments. All appointees of the Active Staff are required to attend at least fifty percent (50%) of the meetings of any committee to which they may be assigned each year.

Section 3. The Courtesy Staff

- A. The Courtesy Staff shall consist of physicians who wish to admit and attend patients in the Hospital, and who are otherwise qualified for such appointment in accordance with these Bylaws. They shall be appointed in the same manner as other appointees of the Medical Staff and they shall have such privileges and duties as may be assigned to them.
- B. Courtesy Staff appointees are not eligible to vote or hold office and are not required to serve on any committees.
- C. Volume parameters: In order to be eligible for Courtesy Staff privileges, a physician must demonstrate a history of and intend to conduct a minimum of five (5) hospital-based encounters annually with a maximum of fifteen(15) hospital based encounters annually.

Section 4. The Consulting Staff

- A. The Consulting Staff shall consist of those physicians who, because of advanced training and experience, are recognized as specialists in their particular field of practice. The Consulting Staff may also include dentists and oral surgeons to the extent permitted by Hospital policy. Consulting Staff appointees may not admit patients but they shall provide consultation when requested by an appointee of the Medical Staff or in those cases where consultation is required by the rules of the Hospital.
- B. Consulting Staff appointees are not eligible to vote, hold office or serve on any committees unless specifically appointed by the President of the Medical Staff.
- C. Consulting Staff appointees shall be appointed in the same manner as other appointees of the Medical Staff.

Section 5. The Honorary Staff

- A. The Honorary Staff shall consist of physicians who, after loyal service to the Hospital, retire from active practice and are invited to become appointees of the Honorary Staff. Physicians of outstanding reputation and achievement may also be invited to become appointees of the Honorary Staff.
- B. Honorary Staff appointees shall have no assigned duties or responsibilities except as authorized by the appropriate department chief. They shall not be eligible to vote at Medical Staff Association meetings and may not hold office. They are not required to serve on committees.
- C. Honorary Staff appointees are exempt from the reappointment process.

Section 6. Allied Health Professional (AHP) Staff

- A. The AHP Staff shall consist of practitioners and scientists in allied health fields, such as acupuncturists, certified registered nurse anesthetists, certified nurse midwives, chiropractors, nurse specialists, nurse practitioners, physician assistants, podiatrists, psychologists, and research scientists. Appointees of the AHP Staff shall have such privileges and duties as may be assigned to them and

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shall be responsible to the appropriate department chief who will define the medical professional qualification status, clinical duties, and clinical responsibilities of each. Any such privileges, duties and responsibilities must be consistent with Hospital policy and the AHP Staff appointee's scope of practice under his or her state license. AHPs shall not be privileged to admit patients; provided, however that nurse practitioners, physician assistants and certified nurse midwives on the AHP Staff may write orders for admission and discharge to the appropriate Medical Staff service to the extent permitted by Hospital policy but it is the responsibility of the Attending Physician of record to sign the orders.

- B. AHPs may attend Medical Staff Association meetings but are not eligible to vote or hold office. They may be invited to serve on and Chair committees.
- C. All AHPs shall be appointed and reappointed, and shall be subject to professional practice evaluation as outlined in Article II of these Bylaws. They may also be granted temporary, emergency and disaster privileges in accordance with Article II, Sections 11, 12 and 13 of these Medical Staff Association Bylaws.

Section 7. The Auxiliary Staff

The Auxiliary Staff shall consist of physicians who wish to refer their patients to a Women & Infants Hospital Active Staff appointee.

The Auxiliary Staff shall be appointed in the same manner as other Medical Staff appointees with the following exceptions:

- They are not required to hold a Rhode Island Medical License but must hold a current Medical License within the United States;
- They are not required to be Board Certified since they will hold no clinical privileges;
- They do not admit patients, hold clinical privileges, write orders in the chart, and they are not subject to focused professional practice evaluation;
- They do not vote, hold office, or serve on any Medical Staff committees unless specifically appointed by the Medical Staff President; and
- They do not pay the full application fee but shall pay a reduced fee as set by Credentials Committee policy.

The Auxiliary Staff may:

- Observe only, but not assist on, clinical and surgical procedures performed on their referred patient;
- Examine their referred patient and discuss their findings and the suggested treatment plan with the Attending Physician; and
- Participate in professional and social life of the Hospital to the greatest extent possible.

Section 8. Per Diem Staff

Per Diem Staff shall consist of physicians, dentists, oral surgeons and AHPs who agree to work per diem according to the Hospital's needs and policies. Per Diem Staff are engaged to work for a specified amount of time/days. Any such privileges, duties and responsibilities must be consistent with Hospital policy and the AHP Per Diem Staff's scope of practice under his or her state license. AHPs on the Per Diem Staff shall not be privileged to admit patients; provided, however that nurse practitioners, physician assistants and certified nurse midwives on the Per Diem Staff may write orders for admission and

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discharge to the appropriate Medical Staff service to the extent permitted by Hospital policy but it is the responsibility of the Attending Physician of record to sign the orders.

**ARTICLE IV
CORRECTIVE ACTION, HEARING AND APPELLATE REVIEW PROCEDURES**

Section 1. Corrective Action Procedure

- A. In the event that the professional activities, behavior or conduct of any member of the Medical Staff violate Hospital policies, rules or regulations or do not conform to the standards required of the Medical Staff, corrective action against such member of the Medical Staff may be requested by any officer of the Medical Staff, the Chief or Associate Chief of any Clinical Department, members of Administration including the Chief Medical Officer, or the Board of Directors.

For the purpose of these Medical Staff Association Bylaws corrective action includes any of the following: imposition of terms of probation or a requirement for consultation; reduction, suspension, restriction or revocation of clinical privileges; or suspension or revocation of appointment or denial of reappointment to the Medical Staff.

- B. Any request for corrective action shall be in writing, shall specify the corrective action requested, shall include a description of the specific activities, behavior or conduct in question and shall be sent directly to the Chief Medical Officer (CMO) **and** chief of the clinical department in which such member of the Medical Staff has clinical privileges (with a copy to the Chairman of the Medical Staff Executive Committee; the Chairman shall promptly send copies to such member of the Medical Staff and to the President/COO of the Hospital). If such member of the Medical Staff is the chief of a department or if the chief of a department is the person making the request for corrective action, the request shall be sent directly to the Chairman of the Medical Staff Executive Committee (with copies to be sent as required above).
- C. The chief of the department shall conduct an investigation concerning the request. The investigation shall include as a minimum the following: an interview with the person making the request; an examination of all documents, records or correspondence which support the request; an interview with the member of the Medical Staff in question; and any other interview or examination which the chief deems appropriate to the investigation. If the member of the Medical Staff in question is the chief of a department or if the chief of a department is the person making the request for corrective action, the chair of the Medical Staff Executive Committee shall select an appointee of the Medical Staff to conduct the foregoing investigation; such appointee shall have had no involvement in the matter and shall not be in direct economic competition with the member of the Medical Staff in question. The interview with the member of the Medical Staff in question shall not constitute a hearing as provided herein, and none of the procedural rules for a hearing shall apply to the interview and the member of the Medical Staff shall not have the right to have a lawyer represent him or her during the interview. The initiation of an investigation shall not preclude the imposition of temporary suspension under Article IV, Section 3 of these Medical Staff Association Bylaws.
- D. The investigation shall be conducted as promptly as possible (not to exceed 60 days), and upon the conclusion of such investigation, the Chief (or Medical Staff appointee) shall submit to the Medical Staff Executive Committee a written report of the investigation (including written summaries of all interviews) and a recommendation for corrective action, if any, with copies to the member of the Medical Staff in question and the President of the Hospital. The Chief (or Medical Staff appointee), for good cause, may extend the time for investigation.

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- E. Upon a receipt of the report and recommendation, the Medical Staff Executive Committee shall, as promptly as possible (not to exceed 60 days), take action upon the request and recommendation. The Medical Staff Executive Committee for good cause may extend the time for action. Unless the Medical Staff Executive Committee rejects the request for corrective action, it shall send written notice to such member of the Medical Staff stating the following:
- (i) The specific corrective action proposed to be taken and the reasons therefore;
 - (ii) The member of the Medical Staff has the right to request a hearing under Article IV, Section 2 herein concerning the proposed corrective action, but such request must be made in writing within thirty (30) days from receipt of the notice or the right to request a hearing and any right to appellate review under Article IV, Section 5 hereof shall be deemed waived;
 - (iii) A summary of the procedural rights in the hearing as set forth in Article IV, Section 2 herein;
 - (iv) If a hearing is not requested, the member of the Medical Staff has the right to request to appear instead before the Medical Staff Executive Committee to make or present a statement, but in such event, he or she will have no right to submit evidence or confront witnesses; such request to appear must be made in writing within thirty (30) days from receipt of the notice or the right to appear shall be deemed waived; and
 - (v) The member of the Medical Staff may be represented by an attorney or other person of his or her choice at the hearing.
- F. After the expiration of the thirty (30) day period specified in the notice of hearing or, if a hearing was requested on a timely basis under Article IV, Sections 1E (ii) and 2A hereof, after the conclusion of the hearing and the delivery of the hearing panel's report, the Medical Staff Executive Committee shall consider the request for corrective action and the hearing panel's report, if any. If requested on a timely basis by the member of the Medical Staff, as provided in Article IV, Section 1E(iv) hereof, the member of the Medical Staff may be permitted to appear before the Medical Staff Executive Committee to make or present a brief statement, but shall not have the right to present evidence or confront witnesses. At the conclusion of its consideration, the Medical Staff Executive Committee shall transmit to the Board of Directors its written recommendation on the request for corrective action (with a copy thereof to the member of the Medical Staff in question).
- G. Within seven (7) days after receipt of a copy of the recommendation of the Medical Staff Executive Committee given pursuant to Article IV, Section 1F herein following a hearing, the member of the Medical Staff may, by written notice to the Board of Directors, request an appellate review by the Board of Directors if the recommendation of the Medical Staff Executive Committee is still adverse to the member of the Medical Staff. Such review shall be conducted in accordance with Article IV, Section 5 of these Medical Staff Association Bylaws. No Medical Staff appointee shall be entitled to more than one (1) hearing and one (1) appellate review relating to the subject matter of any proposed adverse recommendation or action giving rise to a hearing right. If the Board of Directors determines to deny reappointment to an applicant or to revoke or terminate the Medical Staff appointment and/or clinical privileges of an appointee, that individual may not apply for Medical Staff appointment or for those clinical privileges at the Hospital for a period of five (5) years unless the Board of Directors provides otherwise.

Section 2. Hearing – Regular Procedure

- A. If, within thirty (30) days after receiving notice of an action as provided in Article IV, Section 1-E hereof, the member of the Medical Staff requests a hearing concerning proposed corrective action, the Chairman of the Medical Staff Executive Committee shall select, with the approval of the Medical

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Staff Executive Committee, three (3) physicians (who have had no involvement with the matter and who are not in direct economic competition with the member of the Medical Staff in question) to comprise a hearing panel and shall designate one of such three physicians as chairman of the panel.

- B. The panel chairman shall send written notice to the member of the Medical Staff of the place, time, and date of the hearing (which date shall not be less than thirty (30) days or more than sixty (60) days after the date of the notice) and a list of the witnesses expected to testify at the hearing. Said list of witnesses may be supplemented up to seven (7) days prior to the date of the hearing. The panel chairman for good cause may extend the time for hearing.
- C. No less than seven (7) days prior to the hearing, the member of the Medical Staff:
- (i) May request in writing to the panel chairman, and shall have the right to receive, a copy of all reports and documentation used or considered in the request for corrective action and the report of the investigation;
 - (ii) May submit a memorandum concerning any facts or matters which are the subject of the hearing. Such memorandum shall be the Medical Staff member's opportunity to communicate with the hearing panel on substantive issues of the matter outside the hearing itself. In no instance shall the member of the Medical Staff attempt to coerce, influence, or threaten any member of the hearing panel;
 - (iii) Shall notify in writing the panel chairman of the persons he or she desires to call or examine as witnesses at the hearing (the panel chairman shall use his or her best efforts to secure the presence of such persons at the hearing); and
 - (iv) Shall notify the panel chairman in writing if he or she will be represented by an attorney, who shall be identified in such notice.

The panel shall have the right to have legal counsel present to assist and advise it; and the person requesting the corrective action shall have the right to have legal counsel present to represent him or her. If the member of the Medical Staff appears with an attorney without prior written notification thereof to the panel, the panel chairman shall have the right to postpone the hearing until such time as the panel's legal counsel can be in attendance.

- D. Failure of the member of the Medical Staff, without good cause shown, to appear and proceed at the hearing shall be deemed a waiver by the member of the Medical Staff of his or her right to a hearing or any subsequent review or appeal. The opening of the hearing may be postponed for good cause by the member of the Medical Staff on a one time basis. The member of the Medical Staff shall contact the panel chairman and the panel chairman will reschedule the opening of the hearing no later than thirty (30) days after the original date. Once rescheduled, no further requests for postponement shall be considered, and the member of the Medical Staff's failure to appear at a rescheduled hearing shall be deemed a waiver of his or her right to a hearing or any subsequent review or appeal.
- E. At the hearing, the panel chairman shall preside and shall cause a transcript of the hearing to be kept by a certified court reporter retained and paid by the Hospital. A quorum of at least two members of the panel present in person shall be required, and no panel member shall vote by proxy. The panel shall not be bound by the rules of civil procedure and rules of evidence; any relevant evidence, regardless of its admissibility in a court of law, may be introduced and considered so long as personally identifiable confidential health care information is, to the extent possible, not disclosed. Peer review findings or records on other members of the Medical Staff are not considered relevant evidence and may not be introduced at the hearing.
- F. At the hearing, all parties shall have the right to call, examine and cross examine witnesses, present evidence determined by the panel chairman to be relevant and to submit written statements at the

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close of the hearing. The hearing may be postponed or adjourned and continued at the discretion of the panel chairman, provided that the hearing shall conclude within sixty (60) days of the opening of the hearing absent compelling circumstances, as determined by the panel chairman.

- G. Following the close of the hearing, the panel shall prepare and send a written report (together with the hearing record and all other documentation) and recommendation, including a statement of the basis for such recommendation, to the Medical Staff Executive Committee (with a copy to the member of the Medical Staff).

Section 3. Temporary Suspension of Clinical Privileges Procedure

- A. Any of the following, in consultation with at least one other – the Chairman of the Medical Staff Executive Committee, the Chief of a Clinical Department, the President, **Chief Medical Officer** of the Hospital, or the Executive Committee of either the Medical Staff or the Board of Directors – shall have the authority, whenever action must be taken immediately in the best interests of patient care in the Hospital, to suspend temporarily all or any portion of the clinical privileges of a member of the Medical Staff, and such temporary suspension shall become effective immediately upon imposition. At any time prior to a final decision by the Board of Directors on such temporary suspension, the person or committee who imposed the original temporary suspension shall have the authority to rescind such temporary suspension.
- B. Written notice of the imposition of such temporary suspension shall be sent to the member of the Medical Staff as soon as possible. Such notice shall state the following:
- (i) The specific terms of the temporary suspension and the reasons therefore;
 - (ii) The member of the Medical Staff has the right to request a hearing on this matter as promptly as reasonably possible, such hearing to be conducted under Article IV, Section 4 herein, but such request must be made in writing within thirty (30) days from receipt of the notice or the right to request a hearing and any right to appellate review under Article IV, Section 5 hereof shall be deemed waived;
 - (iii) A summary of the procedural rights in the hearing set forth in Article IV, Section 4 herein;
 - (iv) If a hearing is not requested, the member of the Medical Staff has the right to appear instead before the Medical Staff Executive Committee at their next scheduled meeting to make or present a statement, but in such event, he or she will have no right to submit evidence or confront witnesses; such request to appear must be made in writing within thirty (30) days from receipt of the notice or the right to appear shall be deemed waived; and
 - (v) The member of the Medical Staff may be represented by an attorney or other person of his or her choice at the hearing.
- C. If a hearing was requested under Article IV, Sections 3B (ii) and 4A hereof, the Medical Staff Executive Committee shall consider the hearing panel's report and recommendation following receipt. If so requested on a timely basis as provided in Article IV, Section 3B (iv), the member of the Medical Staff shall have the right to appear before the Medical Staff Executive Committee to make or present a brief statement, but shall not have the right to submit evidence or confront witnesses. At the conclusion of its consideration, the Medical Staff Executive Committee shall transmit to the Board of Directors its written recommendation on the matter (with a copy thereof to the member of the Medical Staff in question).
- D. Within seven (7) days after receipt of a copy of the recommendation of the Medical Staff Executive Committee given pursuant to Article IV, Section 3C herein following a hearing, the member of the

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Medical Staff may, by written notice to the Board of Directors, request an appellate review by the Board of Directors if the recommendation of the Medical Staff Executive Committee is still adverse to the member of the Medical Staff. Such review shall be conducted in accordance with Article IV, Section 5 of these Medical Staff Association Bylaws.

- E. The terms of the temporary suspension imposed under Article IV, Section 3A above, as may be sustained, rescinded or modified in whole or in part by the Medical Staff Executive Committee, shall remain in effect pending a final decision thereon by the Board of Directors provided, however, that in the event that the terms of the temporary suspension are so rescinded or modified, the person or committee who imposed the original temporary suspension shall have the right to have such rescission or modification reviewed promptly by the Board of Directors, and such review shall be conducted in accordance with Article IV, Section 5 of these Medical Staff Association Bylaws.
- F. Immediately upon the imposition of a temporary suspension, the Chairman of the Medical Staff Executive Committee or responsible department chief shall have authority to provide for alternative medical coverage for the patients of the suspended member of the Medical Staff still in the Hospital at the time of such suspension, insofar as practical in accordance with the wishes of the patients.

Section 4. Hearing - Temporary Suspension of Clinical Privileges Procedure

- A. If, within thirty (30) days after receiving notice of imposition of a temporary suspension as provided in Article IV, Section 3B hereof, the member of the Medical Staff requests a hearing concerning the temporary suspension, the Chairman of the Medical Staff Executive Committee shall select, with the approval of the Medical Staff Executive Committee, three physicians (who have had no involvement with the matter and who are not in direct economic competition with the member of the Medical Staff in question) to comprise a hearing panel and shall designate one of such three physicians as chairman of the panel.
- B. The panel chairman shall send written notice to the member of the Medical Staff of the place, time and date of the hearing, which hearing shall be held as soon as reasonably possible after the date of the temporary suspension but not less than thirty (30) days or more than sixty (60) days after the date of the notice, and a list of the witnesses expected to testify at the hearing. Said list of witnesses may be supplemented up to seven (7) days prior to the date of the hearing. The panel chairman for good cause may extend the time for hearing.
- C. No less than seven (7) days prior to the hearing, the member of the Medical Staff:
 - (i) May request in writing to the panel chairman, and shall have the right to receive, a copy of all reports and documentation used or considered in the decision resulting in the imposition of the temporary suspension;
 - (ii) May submit a memorandum concerning any facts or matters which are the subject of the hearing. Such memorandum shall be the opportunity for the member of the Medical Staff to communicate with the hearing panel on substantive issues of the matter outside the hearing itself. In no instance shall the member of the Medical Staff attempt to coerce, influence, or threaten any member of the hearing panel;
 - (iii) Shall notify in writing the panel chairman of the persons he or she desires to call or examine as witnesses at the hearing (the panel chairman shall use this best efforts to secure the presence of such persons at the hearing); and
 - (iv) Shall notify the panel chairman in writing if he or she will be represented by an attorney, who shall be identified in such notice.

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The panel shall have the right to have legal counsel present to assist and advise it; and the person who imposed the temporary suspension shall have the right to have legal counsel present to represent him or her. If the member of the Medical Staff appears with an attorney without prior written notification thereof to the panel, the panel chairman shall have the right to postpone the hearing until such time as legal counsel can be in attendance.

- D. Failure of the member of the Medical Staff, without good cause shown, to appear and proceed at the hearing shall be deemed a waiver by the member of the Medical Staff of his or her right to a hearing or any subsequent review or appeal. The opening of the hearing may be postponed for good cause by the member of the Medical Staff on a one time basis. The member of the Medical Staff shall contact the panel chairman and the panel chairman will reschedule the opening of the hearing no later than thirty (30) days after the original date. Once rescheduled, no further requests for postponement shall be considered, and the failure by the member of the Medical Staff to appear at a rescheduled hearing shall be deemed a waiver of his or her right to a hearing or any subsequent review or appeal.
- E. At the hearing, the panel chairman shall preside and shall cause a transcript of the hearing to be kept by a certified court reporter retained and paid by the Hospital. A quorum of at least two members of the panel present in person shall be required, and no panel member shall vote by proxy. The panel shall not be bound by the rules of civil procedure and rules of evidence; any relevant evidence, regardless of its admissibility in a court of law, may be introduced and considered so long as personally identifiable confidential health care information is, to the extent possible, not disclosed. Peer review findings or records on other members of the Medical Staff are not considered relevant evidence and may not be introduced at the hearing.
- F. At the hearing, all parties shall have the right to call, examine and cross examine witnesses, present evidence determined by the panel chairman to be relevant and to submit written statements at the close of the hearing. The hearing may be postponed or continued at the discretion of the panel chairman, provided that the hearing shall conclude within sixty (60) days of the opening of the hearing absent compelling circumstances, as determined by the panel chairman.
- G. Following the close of the hearing, the panel shall prepare and send a written report (together with the hearing record and all other documentation) and recommendation, including a statement of the basis for such recommendation, to the Medical Staff Executive Committee (with a copy to the member of the Medical Staff).
- H. The initial duration of any temporary suspension shall not exceed a period of six (6) months from and after the date of the final decision of the Board of Directors. Prior to the end of the period of initial duration, the Medical Staff Executive Committee shall review the terms and duration of the temporary suspension. In the course of such review, the member of the Medical Staff shall have the right to appear (with or without legal counsel present to represent him or her) before the Medical Staff Executive Committee. Upon completion of such review, the Medical Staff Executive Committee shall recommend to the Board of Directors either:
 - (i) To terminate the temporary suspension; or
 - (ii) To extend the temporary suspension for an additional period up to six (6) months with or without different conditions.

If the Board of Directors decides to extend the temporary suspension for an additional period of up to six (6) months with or without different conditions, then at the end of said additional period, the temporary suspension shall terminate. Except as specifically provided in this Article IV, Section 4H, the member of the Medical Staff shall not be entitled to any hearing or review with respect to any review, recommendation or decision made or taken pursuant to the provisions of this Subsection 4H.

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- I. Nothing herein shall preclude the initiation of further corrective action under Article IV, Section 1 of the Medical Staff Association Bylaws against the member of the Medical Staff during or following the term of the temporary suspension. In the event that initiation of corrective action under Article IV, Section 1 against the member of the Medical Staff commences during the term of the temporary suspension and prior to any hearing on the temporary suspension, then: (i) only one hearing, if requested by the member of the Medical Staff, shall be conducted; (ii) the procedures for hearing under Article IV, Section 2 (Hearing-Regular Procedure) shall be followed instead of the procedures under Article IV, Section 4 (Hearing-Temporary Suspension of Clinical Privileges Procedure); and (iii) the temporary suspension imposed against the member of the Medical Staff shall remain in effect until the conclusion of all proceedings under Article IV, Sections 1 and 2 and, if applicable, Article IV, Section 5.

Section 5. Appeals to the Board of Directors

- A. Time for appeal: Whenever a right of appeal to the Board of Directors is provided for under these Medical Staff Association Bylaws, the affected member of the Medical Staff, on the one hand, or the Medical Staff Executive Committee, or in the case of temporary suspension, the person or committee who imposed the original temporary suspension, on the other hand, may appeal a recommendation within seven (7) days after notice thereof. The request for appellate review shall be in writing and shall be delivered to Administration in the manner provided in Article IV, Section 8 hereof, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances that justify further review. If such appellate review is not requested within seven (7) days as provided herein, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board of Directors for final action. Failure to timely request a hearing as provided in Article IV, Sections 2A or 4A shall be deemed a waiver of any right to appellate review under this Article IV, Section 5.
- B. Grounds for appeal: The grounds for appeal shall be limited to the following:
- (i) There was such substantial failure to comply with the hearing procedures established by this Article IV of the Medical Staff Association Bylaws so as to deny a fair hearing;
 - (ii) The recommendation of the hearing panel was made arbitrarily or capriciously; or
 - (iii) The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.
- C. Time, place, and notice: Whenever an appeal is requested as set forth in the preceding sections, the chairperson of the Board of Directors shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chairperson of the Board of Directors for good cause may extend the time for appellate review.
- D. Nature of appellate review:
- (i) The chair of the Board of Directors shall appoint a review panel composed of not fewer than three (3) members of the Board of Directors to consider the information upon which the recommendation before the Board of Directors was made. Members of the review panel may not be direct competitors of the member of the Medical Staff under review and should not have participated in any formal investigation leading to the recommendation for corrective action or temporary suspension that is under consideration.
 - (ii) The review panel may, but is not required to, accept additional oral or written evidence subject to the same cross-examination and admissibility provisions adopted at the hearing

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- panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit relevant evidence at the hearing was denied.
- (iii) Each party shall have the right to present a written statement in support of its position on appeal. At its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited 30-minute oral argument. The review panel shall recommend final action to the Board of Directors.
 - (iv) The Board of Directors may affirm, modify, or reverse the recommendation of the review panel or, at its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board of Directors' ultimate legal responsibility to grant appointment and clinical privileges.
- E. Final decision of the Board of Directors: Within thirty (30) days after receipt of the review panel's recommendation or if there is no scheduled meeting of the Board of Directors within thirty (30) days after receipt, then promptly after the next scheduled meeting, the Board of Directors shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairpersons of the Credentials Committee and Medical Staff Executive Committee. The final decision of the Board of Directors following the appeal shall be effective immediately and shall not be subject to further review.

Section 6. Limited Appeal Mechanism upon Denial of Initial Application for Appointment and/or Clinical Privileges

A member of the Medical Staff who has received notice of denial of an application for appointment and/or clinical privileges as provided in Article II, Section 4E of these Medical Staff Association Bylaws has the right to request to appear before the Medical Staff Executive Committee to make or present a brief statement, but in such event, he or she will have no right to submit evidence or confront witnesses. Such request to appear must be made in writing in the manner provided in Article IV, Section 8 hereof within thirty (30) days from receipt of such notice or the right to appear shall be deemed waived. At the conclusion of its consideration, the Medical Staff Executive Committee shall transmit to the Board of Directors its decision to uphold the denial of the application or its written recommendation that the Board of Directors reconsider such a denial (with a copy thereof to the member of the Medical Staff in question). A decision of the Medical Staff Executive Committee to uphold a denial shall be final and not subject to further rights of hearing or appeal under this Article IV, Section 6 or otherwise. The member of the Medical Staff will have no right to appear or present evidence before the Board of Directors unless the Board of Directors so requests. The Board of Directors may elect to reconsider a denied application upon the recommendation of the Medical Staff Executive Committee or to uphold the denial. The final decision of the Board of Directors shall be transmitted by Administration to the member of the Medical Staff, with copies to the Chairs of the Executive and Credentials Committees and the chief of the appropriate department. A decision of the Board of Directors to uphold a denial shall be final and not subject to further rights of hearing or appeal under this Article IV, Section 6 or otherwise.

Section 7. Actions Not Giving Rise to Hearing or Appeal Rights

Notwithstanding anything to the contrary in this Article IV, a hearing or appeal right under this Article IV shall not arise in any of the following circumstances:

- A. Issuance of a letter of guidance, warning, or reprimand;
- B. Imposition of a requirement for proctoring (i.e., observation of the performance of the member of the Medical Staff by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on privileges;

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- C. Failure to process a request for a privilege when the applicant/appointee does not meet the eligibility criteria to hold that privilege;
- D. Conduct of an investigation into any matter;
- E. Automatic suspension in connection with government action relating to participation in any federal health care program as provided in Article II, Section 1 of these Medical Staff Association Bylaws;
- F. Automatic relinquishment or voluntary resignation of appointment or privileges;
- G. Imposition of a precautionary or disciplinary suspension or administrative time out that does not exceed fourteen (14) days;
- H. Denial of a request for leave of absence, or for an extension of a leave;
- I. Determination that an application is incomplete or untimely;
- J. Determination that an application will not be processed due to misstatement or omission;
- K. Decision not to expedite an application;
- L. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;
- M. Determination that an applicant does not meet the requisite qualifications/criteria for appointment or privileges;
- N. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;
- O. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted or if exhaustion of due process rights is pending;
- P. Termination of any contract with or employment by the Hospital;
- Q. Proctoring, monitoring, and any other performance monitoring requirements imposed under the Medical Staff Association Bylaws or in order to fulfill Joint Commission standards on focused professional practice evaluation;
- R. Any recommendation voluntarily accepted by the member of the Medical Staff;
- S. Expiration of appointment or privileges as a result of failure to submit an application for reappointment within the allowable time period;
- T. Change in assigned Medical Staff category;
- U. Refusal of the Credentials Committee or Medical Staff Executive Committee to consider a request for appointment, reappointment, or privileges within one year of a final adverse decision regarding such request;
- V. Removal or limitation of emergency department call obligations;
- W. Any requirement to complete an educational assessment;
- X. Retrospective chart review;
- Y. Any requirement to complete a health and/or psychiatric/psychological assessment required under the Medical Staff Association Bylaws;
- Z. Grant of conditional appointment or appointment for a limited duration;
- AA. Appointment or reappointment for a duration of less than 24 months; or
- BB. Termination, revocation or expiration of emergency or disaster privileges as provided in Article II, Sections 11 and 12 of these Medical Staff Association Bylaws.

Section 8. Notices

Any notice required to be given under this Article IV shall be in writing and sent by first class mail or registered or certified mail, postage prepaid, or by traceable overnight delivery service, delivery charges prepaid, in each case addressed to the party to receive such notice. Such notice shall be deemed given, in the case of overnight delivery, the day following delivery to the carrier, or, in the case of certified mail, the earlier of the date of confirmed receipt or three (3) days after the date of postmark, or, in the case of first class mail, three (3) days after the date of postmark.

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**ARTICLE V
BOARD OF MEDICAL LICENSURE AND DISCIPLINE REVIEW**

From time to time the Hospital may be informed by the Rhode Island Board of Medical Licensure and Discipline or other governmental authorities or boards that an adverse action has been taken against a Medical Staff appointee by such authority or by another Hospital at which the appointee has privileges. The Hospital President shall forward the notice to the Medical Staff Association President who shall convene an ad hoc committee composed of the Medical Staff Association President (or his or her designee), the Medical Staff appointee's department chief (unless the department chief is the subject of the adverse action), the Credentials Committee Chair, and the Hospital President (or his or her designee). A preliminary inquiry of the involved Medical Staff appointee's privileges must be initiated (but not necessarily completed) within thirty (30) days of receipt of the aforementioned notice. If upon such initial inquiry the Hospital and/or the Medical Staff Association becomes concerned about the Medical Staff appointee's privileges, competence, professionalism, provision of patient care or compliance with Medical Staff Association Bylaws, department rules and regulations or Hospital policy, the Medical Staff appointee may be immediately suspended, as discussed in Medical Staff Bylaws, Article IV, Section 3 which will be followed at that point. If immediate suspension is not recommended, the ad hoc committee shall complete its inquiry within sixty (60) days with an extension period of an additional sixty (60) days, if needed. If the external sanction exceeds this one-hundred twenty (120) day period, the inquiry period may be extended, with documented good reason, by no more than sixty (60) additional days. The ad hoc committee shall review the governmental authority's or board's disciplinary action and also consider the Medical Staff appointee's clinical performance and professional conduct. If no additional disciplinary action is recommended, no further action will be taken. Upon the sanction period's completion, the Medical Staff appointee shall provide the ad hoc committee written documentation of its disposition and/or of the Board of Medical Licensure and Discipline's or other governmental authority's or board's further action, if any. Should such inquiry require further disciplinary action, such shall be conducted as required in Medical Staff Association Bylaws, Article IV, Sections 1 and 2. Nothing in this Article V shall be deemed to limit or diminish the authority of any officer or representative of the Hospital or Medical Staff to take such corrective action with respect to a member of the Medical Staff as is permitted within Medical Staff Association Bylaws Article IV.

**ARTICLE VI
PATIENT ADMISSION, DISCHARGE, RECORDS, CARE AND EMERGENCY SERVICES**

Section 1. Admission and Discharge of Patients

- A. A patient may be admitted to the Hospital only by an appointee of the Medical Staff; provided, however that nurse practitioners, physician assistants and certified nurse midwives on the Medical Staff may write orders for admission and discharge to the appropriate Medical Staff service to the extent permitted by Hospital policy but it is the responsibility of the Attending Physician of record to sign the orders. All physicians, nurse practitioners, physician assistants and certified nurse midwives shall be governed by the official admitting policy of the Hospital. Qualified consultants who are not appointees of the Medical Staff may attend a specific patient with the approval of the chief of the appropriate department.
- B. An Attending Physician shall be responsible ultimately for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and of transmitting reports of the condition of the patient to the physician who referred the patient to the Hospital and (subject to requirements of patient confidentiality) to relatives of the patient. Whenever care or on-call responsibility is transferred, a person to person report including the patient's demographics, assessment, treatment(s) and future actions shall be

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communicated to the next provider of service. Additionally, when these responsibilities are transferred to another Medical Staff appointee, a note covering the transfer of responsibility shall be entered in the medical record.

B. Only fully-credentialed, and appropriately privileged, members of the Medical Staff may provide, or assume coverage for group practices.

C. All newborn patients will be seen by a credentialed provider prior to their discharge.

D. All Admitting Physicians are required to provide for a capability of response to calls regarding their inpatients within 30 minutes after admission. Response can be by an Attending Physician or through a clearly designated coverage plan present on the general call schedule.

In the emergency /obstetric triage unit the response time to calls must be within 15 minutes. If the Admitting Physician or his or her clearly designated coverage is not able to assume in-person direct care of his or her patient within 30 minutes in the emergency/obstetric triage unit, the care of his or her patient will proceed under the supervision of the Medical Staff appointee assigned to cover the emergency/obstetric triage unit.

E. No patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

F. Private patients shall be attended by their own physician. Patients who do not have a physician who is an appointee of the Medical Staff shall be assigned to an appropriate service.

G. An Attending Physician is required to document the need for continued hospitalization after extended periods of stay as defined by the Hospital's Care and/or Utilization Management Plan.

H. Medical and House Staff shall meet all Hospital requirements for utilization review and quality assurance consistent with the Care Management Department policies and procedures for Admission, Transfer and Discharge, governmental regulations and other accrediting standards.

I. Patients shall be discharged only under the direction of an Attending Physician.

J. Should a patient leave the Hospital against the advice of an Attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical records. Whenever possible an attempt shall be made to have the patient sign the proper form to free the Hospital and the Attending Physician of liability when the discharge is against medical advice.

K. In the event of a Hospital death, the patient shall be pronounced dead by an Attending Physician or his or her physician designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by an appointee of the Medical Staff and death certificate completed.

L. Every appointee of the Medical Staff shall be actively interested in securing autopsies in accordance with Hospital policy. No autopsy may be performed without the written consent of the responsible relative, unless ordered by the State Medical Examiner. Pathology is responsible for notifying an Attending Physician regarding time and place of autopsy. All autopsies shall be performed by the Hospital pathologist, or by a physician appointed by him or her. Following completion of the autopsy, provisional anatomic diagnoses shall be recorded on the medical record within two working days and the complete autopsy report shall be a part of the record within sixty (60) days, except in

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complicated cases requiring special studies in which case the completed autopsy report shall be a part of the record within ninety (90) days.

- M. All releases of protected health information are subject to applicable State and Federal confidentiality laws.

Section 2. Medical Records

- A. An Attending Physician, determined in accordance with Hospital medical records policy, shall be responsible ultimately for the preparation of a complete and legible medical record for each patient. Each entry in the medical record must be dated, timed and authenticated. Its contents shall be pertinent and current. This record shall include, as appropriate, patient's identification, medications, admission date(s), chief complaint, history of present illness, past medical history, significant family history, physician examination, initial assessment, plan of care, special reports such as, consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; nurse, AHP and physician (and dentist or oral surgeon if applicable) progress notes; final diagnosis; condition on discharge; discharge summary or note; autopsy report when performed and all consent forms. This applies to inpatients and appropriate outpatients.
- B. (i) A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services (and in accordance with hospital policy). The medical History and Physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), or other qualified licensed individual in accordance with State law and hospital policy.
- (ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act) or other qualified licensed individual in accordance with State law and hospital policy.
- (iii) The entire prenatal record can be utilized as the history and physical, provided it is updated to reflect the patient's condition upon admission and prior to surgery or a procedure requiring anesthesia.
- C. When a physician on the House Staff performs a history and physical examination it is the obligation of the Attending Physician to document his or her approval. The admission history and physical examination of patients under the care of the House Staff is to be authenticated by the physician performing the examination. The Medical Record of House Staff patients must be maintained in accordance with applicable Hospital medical record policies.
- D. Pertinent progress notes shall be recorded at the time of observation and to justify continued hospitalization. Progress notes shall be written at least daily by the Attending Physician or by an appropriate member of the AHP Staff to the extent permitted by Hospital policy and consistent with the AHP Staff appointee's scope of practice under his or her state license. This applies to inpatients and appropriate outpatients.

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- E. A brief operative note or high risk procedure report shall be included in the medical record. The operative or high risk procedure report(s) **shall be written or dictated immediately following surgery or a procedure.** An operative or high risk procedure progress note shall be entered in the medical record immediately after surgery or a procedure to provide pertinent information for anyone required to attend to the patient. This applies to outpatients as well as inpatients. If the operative or high risk procedure report is not written or dictated within forty-eight (48) hours after completion of the operation or a procedure, the responsible Attending Physician will lose his or her elective admitting privileges until the operative or high risk procedure report is written or dictated or written in the electronic medical record. When a physician on the House Staff or a member of the AHP Staff writes or dictates the operative note or high risk procedure report it is the obligation of the Attending Physician to approve and authenticate it.
- F. A Consulting Staff appointee shall show evidence of a review of the patient's record, pertinent findings, and his or her opinion and recommendations.
- G. All clinical entries in the patient's medical record shall be authenticated and accurately dated and timed.
- H. Only symbols and abbreviations approved by the Medical Staff may be used. A copy of the approved symbols and abbreviations is on file in the Health Information Management Department.
- I. A discharge summary must include a summary of hospitalization events, disposition of the case, provisions for follow-up care and final diagnosis and shall be completed on all medical records of surgical patients hospitalized over twenty-four (24) hours and on medical records of non-surgical and NICU patients hospitalized over 48 hours and on NICU patient stays less than forty-eight (48) hours with complications (including death) (exceptions: normal newborn infants and uncomplicated obstetrical deliveries). Discharge summaries must be completed within forty-eight (48) hours of discharge. If a Medical Staff member fails to complete a discharge summary within forty-eight (48) hours of discharge, Health Information Management (HIM) will notify the Medical Staff member of such non-compliance, and if the Medical Staff member fails to complete the discharge summary within two (2) business days of receiving notice from HIM, this may, at the discretion of the CMO, result in an administrative suspension of all clinical privileges until such time as the discharge summary is complete. Uncomplicated obstetrical deliveries are defined as: 1) vaginal deliveries without obstetrical or medical complications, and 2) uncomplicated vaginal deliveries with uncomplicated post-partum tubal ligation. A final progress note will suffice for these exceptions and for surgical stays of twenty-four (24) hours or less and non-surgical and NICU stays of forty-eight (48) hours or less. All discharge summaries shall be authenticated by the Attending Physician, an appropriate member of the House Staff under the direction of the Attending Physician or by an appropriate AHP Staff appointee to the extent permitted by Hospital policy and consistent with the AHP Staff appointee's scope of practice under his or her state license
- J. All births must be certified within 4 days of the provider being notified by the State certification system. Failure to meet this requirement may result in immediate administrative suspension of delivery privileges.
- K. A patient's confidential health care information shall not be released or transferred without the written consent of such patient or his or her authorized representative except as provided in Subsections 2K and 2L below or as otherwise specifically provided by the law.

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- L. Records may be removed from the Hospital's jurisdiction and safekeeping only with the written approval from the Hospital Risk Management Department. Unauthorized removal of medical records is grounds for suspension of Medical Staff Privileges for a period to be determined by the Medical Staff Executive Committee of the Medical Staff.
- M. Access to medical records shall be afforded to Medical Staff appointees and other authorized personnel consistent with preserving the confidentiality of the information and in accordance with Health Information Management Department policy. Abuse of this rule will be reported to the Medical Staff Executive Committee for appropriate corrective action.
- N A medical record shall not be permanently filed until it is completed by the appropriate Medical Staff appointee, or by an appropriate member of the House Staff to the extent permitted by Hospital policy and these Bylaws, or it is approved to be filed by the Medical Records Committee.
- O. Orders shall be documented in detail in the patient's record, timed, dated and authenticated by the ordering Medical Staff physician appointee or his or her Medical Staff designee or by an appropriate Medical Staff AHP appointee or House Staff Member to the extent permitted by Hospital policy.
- P. Record keeping by medical students shall be in accordance with the more specific policies and procedures set forth by the Medical Records Committee in conjunction with the Graduate Medical Education Committee.
- Q. The Medical Record Committee will be responsible for development, review, revision and implementation of policies and procedures related to the specific content of items in the medical record. These policies and procedures will be maintained by the Health Information Management Department and distributed, as appropriate, to the Medical Staff.

Section 3. General Conduct of Care

- A. The appropriate consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained prior to or on admission. Whenever possible, consents for obstetrical care should be obtained prior to admission. The ultimate responsibility for obtaining the properly executed consent form(s) rests with the Admitting Physician. The standard Hospital forms approved by the Medical Staff are to be used in all cases.
- B. Medical Staff appointees shall arrange to have testing for elective surgery patients performed on a preadmission basis as per Hospital protocol.
- C. All orders for treatment shall be appropriately documented. Telephone orders may be dictated only to Medical Staff, House Staff or Licensed Registered Dietitians, Registered Nurses or Pharmacists and shall be signed, timed, and dated by the Medical Staff appointee or House Staff member, Licensed Registered Dietitian, Registered Nurse, or Pharmacist to whom they were dictated with the name of the ordering Medical Staff appointee or House Staff member. Verbal orders (when ordering Medical Staff appointee or House Staff member physically present on the unit) may only be given in emergencies or when the ordering Medical Staff appointee or House Staff member is scrubbed. The ordering Medical Staff appointee or House Staff member shall authenticate all telephone orders and verbal orders within 24 hours. Telephone or Verbal Orders will not be carried out until they are read-back to and verified by the ordering Medical Staff appointee or House Staff member.

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- D. The ordering Medical Staff appointee or House Staff member's orders must be documented clearly, legibly and completely and include date and time of entry. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the individual carrying out the order.
- E. All previous orders are cancelled when patients go to surgery except for postpartum tubal ligation patients.
- F. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Services, A.M.A. Drug Evaluations, or such other nationally recognized publications as may be approved by the appropriate Peer Review Committee. Drugs for bona fide clinical investigations as approved by the Institutional Review Board are exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Food and Drug Administration.
- G. Narcotics, sedatives, antibiotics and anticoagulant drugs that are ordered without time limitation of dosage shall be automatically discontinued after seventy-two (72) hours.
- H. House Staff function under the direction of the department chief to whom they are assigned. Under this supervision they may write orders and order medications. House Staff must complete their medical record obligations within thirty (30) days following the patient's discharge. In the event that the medical records are not complete within thirty (30) days of discharge, the department chief will suspend the responsible House Staff member from duty until such time as the records are complete.
- I. Individual House Staff members may assist Attending Physicians who are not employed by the Hospital. When acting in this capacity, they are under the supervision of the non-employed Attending Physician.
- J. Medical students shall not have the authority to write orders. Orders may be written only by Medical Staff appointees or by an appropriate member of the House Staff under the supervision of the Attending Physician; provided, however, orders may only be written by AHP Medical Staff members and AHP House Staff members to the extent permitted by Hospital policy and consistent with the AHP Staff appointee's scope of practice under his or her state license.
- K. If any clinical caregiver has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he or she shall call this to the attention of the supervisor, who in turn may refer the matter to the **Chief Medical Officer** and the Senior VP of Patient Care Services. If warranted, the **Chief Medical Officer** and Senior VP of Patient Care Services may bring the matter to the attention of the chief of the department wherein the Medical Staff appointee has clinical privileges. Where circumstances are such as to justify such action, the chief of the department may conduct an investigation.

Section 4. General Rules Regarding Surgical Care

- A. Each operating surgeon shall be assisted at all major operations by a qualified assistant. A qualified assistant is one who's training and skills in the opinion of the respective department chief are deemed satisfactory for the anticipated procedure.
- B. Elective surgical patients will not receive preoperative medication until the history and physical examination and signed consent form are recorded in the chart.

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- C. Except in severe emergencies, the preoperative diagnosis, required laboratory tests, history and physical examination (See Article VI, Section 2B), and signed consent form must be recorded on the patient's medical record prior to any surgical procedure. Even in a severe emergency, the Attending Physician, an appropriate member of the House Staff under the direction of the Attending Physician or an appropriate AHP Staff appointee, to the extent permitted by Hospital policy and consistent with the AHP Staff appointee's scope of practice under his or her state license, shall make at least a summary note regarding the patient's condition prior to induction of anesthesia and start of surgery.
- D. Written, signed, informed consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.
- E. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.
- F. All tissue, except those exempted by the Medical Staff, shall be sent to the Hospital pathologist who shall make such examination as may be necessary to arrive at a diagnosis. The approved list of exempted tissue is on file in the Department of Pathology & Laboratory Medicine.

Section 5. Emergency Services

- A. The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the Hospital's basic plan for the delivery of such services.
- B. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record. The record shall include:
 - (i) Adequate patient identification;
 - (ii) Information regarding the time of the patient's arrival, condition, and medications;
 - (iii) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his or her arrival at the Hospital;
 - (iv) Description of significant clinical and laboratory findings;
 - (v) Diagnosis;
 - (vi) Treatment given;
 - (vii) Condition of the patient on discharge or transfer; and
 - (viii) Final disposition including instruction given to the patient and/or his or her family, relative to necessary follow-up care.
- C. Each patient's medical record shall be signed by an Attending Physician, who is responsible for its clinical accuracy.
- D. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be approved by the Medical Staff and Board of Directors and be available to appointees of the Medical Staff. Appointees of the Medical Staff are expected to participate in a manner defined in the Disaster Plan.

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**ARTICLE VII
CLINICAL DEPARTMENTS**

Section 1. Organization of Departments, Clinical Services and Consult Services

All Clinical Departments, Clinical Services, and Consult Services as described below shall be organized as part of the Medical Staff and shall have a chief who shall be responsible to the Hospital, and the Medical Staff Executive Committee for the proper functioning of the department or service and supervise the clinical work within the department.

Section 2. Departments, Clinical Services, and Consult Services

There shall be six major Departments as well as multiple other Clinical Services and Consult Services.

- A. A Major Department shall represent a clinical specialty based on volume and activity and shall fulfill the requirements of the Joint Commission and other regulatory agencies.

Major Departments are the following: Anesthesiology, Diagnostic Imaging, Medicine, Obstetrics and Gynecology, Pathology and Laboratory Medicine and Pediatrics

- B. Clinical Services represent specialties whose providers hold Admitting or Courtesy privileges and include the following: Family Medicine, Surgery.
- C. Consult Services include specialties with Consulting level of privileges only and include, for example, adult Cardiology, Neurology, Ophthalmology, Psychiatry, Urology as well as equivalent Pediatric medical and surgical subspecialties

Section 3. Roles and Responsibilities: Chiefs of Major Departments, Clinical Services and Consult Services shall:

- A. Qualifications: The chief of clinical departments, Clinical Services and Consult Services shall be Board Certified in the specialty in which he or she practices, shall be an appointee of the Active Staff and shall be qualified by training, experience, and demonstrated clinical and administrative ability for the position.
- B. Selection: The Board of Directors shall appoint a chief for each clinical department, considering recommendations of the Medical Staff Executive Committee and Administration. The department chief also shall be responsible through Administration to the Board of Directors.
- C. Term: Terms of appointments of department chiefs shall be determined by the Board of Directors.
- D. Roles and Responsibilities: Chiefs of Major Departments, Clinical Services and Consult services shall:
1. Supervise clinically and administratively related activities of the department unless otherwise provided by the hospital;
 2. Provide continued surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
 3. Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

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4. Recommend clinical privileges for each Medical Staff member of their respective specialty. Family Medicine recommends clinical privileges jointly with the Departments of Medicine, Obstetrics and Gynecology and Pediatrics as per the approved agreement of the Medical Executive Committee.
5. Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
6. Provide integration of the department or service into the primary functions of the organization;
7. Provide coordination and integration of interdepartmental and intradepartmental services;
8. Develop and implement policies and procedures that guide and support the provision of care, treatment, and services;
9. Provide recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
10. Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
11. Continuous assessment and improvement of the quality of care, treatment, and services;
12. Assist with the maintenance of quality control programs, as appropriate;
13. Provide orientation and continuing education of all persons in the department or service;
14. Recommend space and other resources needed by the department or service;
15. Appoint an Active Staff appointee as his or her designee, who shall have the authority to conduct departmental functions in his or her absence, and appoint committees as needed to conduct departmental functions;
16. Be responsible for enforcement of the Hospital Bylaws, Rules & Regulations, and Medical Staff Association Bylaws, departmental rules and regulations and policies;
17. Be responsible for implementation within the department of actions taken by the Medical Staff Executive Committee;
18. Establish policies and procedures for the supervision and training of House Staff and medical students and set forth the requirements for promotion within and completion of the residency or fellowship including clinical duties, committee activities, and completion of medical records;
19. Participate in every phase of administration of the department as well as inter-departmental matters through cooperation with the Nursing Service, and Administration and matters affecting patient care, including budgeting, planning, personnel, supplies, special regulations, standing orders, and techniques; and assessing and recommending to Administration off-site sources for needed patient care services not provided by the department or the organization;
20. Assist in the preparation of such Annual Reports (including budget planning, Hospital Annual Reports and long-term planning) as may be required by the Medical Staff Executive Committee, Administration, and the Board of Directors;
21. Designate, with the approval of the Medical Staff Executive Committee, various chiefs of divisions in the department as may be deemed needed by him or her for the efficient management of the department; and
22. Report on a monthly basis to the Medical Staff Executive Committee about the functioning of the department.

Section 4. Function of Departments, Clinical Services and Consult Services

- A. Major Departments: Each active department shall have written rules and regulations concerning its structure, function, and conduct of meetings. These are to include, but not be limited to: the organization of the department; frequency of meetings and election of department officers; responsibilities of appointees; and establishing criteria for the granting of clinical privileges, and policies and procedures for the conduct of department activities. Such written rules and regulations

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are to be approved by the Medical Staff Executive Committee and the Board of Directors. Each active department shall establish mechanisms for ensuring the quality of care rendered by its appointees.

- B. Clinical Services and Consult Services: Each Clinical Service and Consult Service shall establish written rules and regulations concerning its structure and function, including criteria for the granting of clinical privileges, which shall be approved by the Medical Staff Executive Committee and the Board of Directors. Clinical services and Consult services appointees are encouraged to participate fully in general Medical Staff conferences and meetings. Consulting Departments are not required to hold regular departmental meetings, but appointees are encouraged to participate in meetings of Active Departments, and to fully participate in general Medical Staff conferences and meetings.

**ARTICLE VIII
OFFICERS**

Section 1. Officers

- A. The officers of the Medical Staff Association are: President, President-Elect, Secretary, Treasurer, and Immediate Past President. All appointments for Officers will be approved by the Board of Directors.
- B. Qualifications: Only voting appointees of the Active Staff in good standing shall be elected and hold officer positions. A Medical Staff appointee must also meet the following qualifications:
- Be an appointee of the Active Staff in good standing for not less than four (4) years prior to being elected President or President-elect, and remain in good standing during their term of office;
 - Be actively involved in patient care in the Hospital;
 - Have previously served in a significant leadership position on a Medical Staff (e.g. department or division chair, committee chair);
 - Indicate a willingness and ability to serve;
 - Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
 - Be willing to participate in leadership training during his or her term of office, if requested;
 - Have demonstrated an ability to work well with others;
 - Be in compliance with the professional conduct policies of the Hospital; and
 - Have excellent administrative and communication skills.

The Nominating Committee will have discretion to determine if a Medical Staff appointee wishing to run for office meets the qualifying criteria.

Officers and Medical Staff Executive Committee at-large members may not simultaneously hold a leadership position on another hospital's medical staff or in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the Board of Directors determines that allowing the officer to maintain his or her position is in the best interest of the Hospital. The Board of Directors shall have discretion to determine what constitutes a "leadership position" at another hospital.

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- C. **Term of Office:** The President, Secretary and Treasurer shall be elected to serve two year terms. These terms are to begin on December 1st of the year in which they are elected and continue until their successor assumes office.

The Immediate Past President shall serve a two year term. The term shall begin on December 1st of the year in which he or she gives up the office of President and continue for two years.

The President-Elect shall serve a two year term. This term is to begin on December 1st of the year he or she is elected and continue for two years at which time he or she will assume the role of President.

- D. **Removal:** Any officer of the Medical Staff may be removed from office by a two-thirds vote of the Medical Staff Executive Committee with approval of the Medical Staff Association and the Board of Directors. Removal shall be only for cause, which shall include, but not be limited to: (i) inability or unwillingness to perform the duties of the office, or (ii) unprofessional conduct in the performance of official duties. Loss, termination, suspension or restriction of Medical Staff appointment and/or clinical privileges or state license to practice medicine will result in automatic removal from office.
- E. **Vacancies:** If before the expiration of the term for which he or she was elected, the President resigns, becomes disqualified or in any other way is unable to fulfill the duties of the office, the President-elect shall succeed to the office vacated, with all the prerogatives and duties pertaining to the office. Vacancies created by death, resignation, or disqualification of other officers and vacancies and contingencies not here within provided shall be filled by election.
- F. **Duties:** In general, in addition to the rights and duties provided elsewhere in these Bylaws or as custom or parliamentary usage may require, the officers shall have the rights and duties respectively assigned them in the succeeding paragraphs of this section.

President – The following are the rights and duties of the President: 1) to preside at all meetings of the Medical Staff Association, Board of Directors Patient Care Evaluation Committee, and Medical Staff Executive Committee; 2) to serve as an ex-officio member of the Board of Directors; 3) to serve as an ex-officio member of all committees and as their chair where not otherwise provided for within these Bylaws; 4) to inform the Board of Directors of committee activities; 5) to prepare an address for presentation at the Annual Meeting of the Corporation; and 7) to perform such other duties as he or she may be assigned by the Medical Staff Association or Board of Directors in accordance with Medical Staff Association Bylaws and Hospital Bylaws.

President-elect – The President-elect shall be a member of the Medical Staff Executive Committee, and an ex-officio member of all other standing and Ad Hoc Medical Staff committees. During the term of his or her office he or she shall maintain familiarity with the affairs of the Medical Staff Association. In the absence of the President he or she will assume all the prerogatives and duties of the office.

Secretary – The following are the rights and duties of the Secretary: 1) to serve as Secretary of the Medical Staff Executive Committee; 2) to keep minutes of the Medical Staff Association meetings; 3) to keep a register of all appointees on the Medical Staff of the Hospital; 4) to be custodian of all record books and papers of the Medical Staff Association except such as properly belongs to the Treasurer; and 5) to perform such other duties as may be required by the Medical Staff Association.

Treasurer – The following are the rights and duties of the Treasurer: 1) to serve as member of the Medical Staff Executive Committee; 2) to bill and collect charges from Medical Staff appointees and

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to deposit same in a depository approved by the Medical Staff Association, and to keep accurate record thereof as well as of funds disbursed by the Medical Staff Association; 3) pay all bills authorized by the Medical Staff Association; 4) report on a monthly basis to the Medical Staff Executive Committee the balances in all accounts he or she manages; 5) report on a quarterly basis to the Medical Staff Association the balances in all accounts he or she manages; 6) under the direction of the Medical Staff Executive Committee to invest the funds under his or her care; 7) to subject his or her accounts to examination by the auditors annually; and 8) to secure such assistance as may be authorized by the Medical Staff.

Immediate Past President – The following are the rights and duties of the Immediate Past President: 1) to serve as a member of the Medical Staff Executive Committee; and 2) to lend assistance to the President, and to perform the duties of the President in the absence of the President and President-elect.

**ARTICLE IX
COMMITTEES**

There shall be standing and special committees. All committee members other than members of the Medical Staff Executive and Credentials Committees shall be appointed by the President of the Medical Staff Association. Chairs, upon approval of the President of the Medical Staff Association, may add members to committees not provided for elsewhere in these Bylaws. The President of the Medical Staff Association shall also appoint Chairs of any committees whose election are not provided for elsewhere in these Bylaws. All committee appointments shall be for a period of one year beginning with the calendar year, except for the Medical Staff Executive Committee which runs for one year beginning with the Annual Meeting of the Medical Staff Association.

Section 1. Medical Staff Executive Committee

A. Purpose: This committee shall coordinate the activities and general policies of the Medical Staff Association, and act for the Medical Staff Association as a whole, and shall have the following responsibilities:

1. To represent and act on behalf of the Medical Staff Association, subject to such limitations as may be imposed by these Bylaws;
2. To coordinate the activities and general policies of the various departments and review written rules and regulations of the Clinical Departments;
3. to receive and act upon department and committee reports, including those used to organize the quality assurance and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities;
4. To implement policies of the Medical Staff not otherwise the responsibility of the departments;
5. To provide liaison with the Medical Staff Association, Administration, and the Board of Directors;
6. To recommend action to Administration on matters of a medico-administrative nature;
7. To fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to patients in the Hospital;
8. To keep the Medical Staff abreast of the accreditation program and informed of the accreditation status of the Hospital;
9. To review Credentials Committee minutes for the purpose of making recommendations for initial Medical Staff appointment, department assignment and clinical privilege delineation,

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- reappointment, renewals or changes in clinical privileges, and changes in status, or further review the credentials of applicants when deemed necessary;
10. To promote professionally ethical conduct and competent clinical performance on the part of all appointees of the Medical Staff, including the initiation of and/or participation in Medical and AHP Staff corrective or review measures when warranted;
 11. To meet at least once a month and to keep a permanent record of its proceedings; and
 12. To report at each General Medical Staff meeting.
- B. Composition: The Medical Staff Executive Committee shall consist of Officers of the Medical Staff Association; the Chiefs of the following Active Departments: Anesthesiology, Diagnostic Imaging, Medicine, Obstetrics & Gynecology, Pathology & Laboratory Medicine, and Pediatrics; the Chief of Surgery; the Director of Medical Education; Administration, the CMO, the Chief Nursing Officer and nine other appointees of the Active Staff (members-at-large) who shall serve a term of three years. The terms of the members-at-large shall be so staggered as to allow election of three members-at-large annually by the Medical Staff Association. A member-at-large may be eligible for re-election after one year has elapsed. The President of the Medical Staff Association shall be its Chair.
- C. Removal: Any Medical Staff Executive Committee member can be removed by a two-thirds vote of the Medical Staff Executive Committee, with the approval of the Medical Staff Association and the Board of Directors for cause, which shall include but not be limited to: inability or unwillingness to perform the committee membership duties. Loss, termination, suspension or restriction of Medical Staff appointment and/or clinical privileges or state license to practice medicine will result in automatic removal from the Medical Staff Executive Committee. Vacancies created by removal shall be filled by appointment or election by the person or body having authority to appointment or elect the committee member so removed.
- D. Frequency of Meetings: Monthly and at the call of the Chair
- E. Responsible to: Medical Staff Association and the Board of Directors

Section 2. Credentials Committee

- A. Purpose: The purpose of this committee is to investigate the credentials of all new applicants for appointment to the Medical Staff and make its recommendations to the Medical Staff Executive Committee. It shall review prior to reappointment all information available from department chiefs and Medical Staff committees regarding the performance of appointees. As a result of such reviews it shall make recommendations for the granting of staff category and clinical privileges (including increase or curtailment thereof) or non-reappointment (including reason(s) why) in order to promote the delivery of safe, quality care and to encourage open discussions and candid self analysis to ensure that medical care of high quality will be available to the public.
- B. Composition: The Chief of Obstetrics/Gynecology and Pediatrics shall each elect one person to serve on the Committee; three members shall be appointed by the President of the Medical Staff Association, one of whom shall be a pediatrician; one member-at-large shall be elected by the general Medical Staff to serve on the Committee; and one representative each from Administration and the Board of Directors. The Chair of the Committee shall be appointed by the President of the Medical Staff Association.
- C. Frequency of Meetings: Monthly and at the call of the Chair
- D. Responsible to: Medical Staff Executive Committee

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Section 3. Quality Council

- A. Purpose: To promote the delivery of safe, quality care as a foremost priority and to hold leadership, clinical units, and committees accountable for achieving our quality and safety goals. To determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care. To encourage open discussions and candid self-analysis, to ensure that medical care of high quality will be available to the public. The Council will achieve its mission by: (i) assisting all clinical units and committees with the development and meeting of meaningful quality goals; (ii) determining and monitoring priority quality and risk indicators; and (iii) approving and monitoring timely completion of action plans related to unanticipated adverse clinical events.
- B. Composition: The CMO in consultation with the department chiefs, shall appoint physicians. Non-physician members include: Administration, Patient Care Services, Information Services, Pharmacy, Quality Management and Risk Management and others as appropriate.
- C. Frequency of Meetings: **Will meet throughout the year.**
- D. Responsible to: Medical Staff Executive Committee, Strategic Leadership Team and Quality Committee of the Board of Directors

Section 4. Peer Review Committees (Including, but not limited to: Obstetrics, Gynecology and Surgery, Acute Monitoring Service, Triage/Emergency, Pediatric/Neonatal, Perinatal Mortality, Robotic Surgery, Utilization Review)

- A. Purpose: To study on an as needed basis any matter relative to the appropriateness of care rendered by a member of the Medical Staff, or Administration, and may also be made on the basis of established clinical triggers. To evaluate and improve the quality of health care rendered by Medical Staff appointees or to determine that health care services rendered by Medical Staff appointees were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health care services in the area. To encourage open discussions and candid self-analysis, to ensure that medical care of high quality will be available to the public.
- B. Composition: Members of the Committee will be appointed by the President of the Medical Staff who will also appoint a physician to chair the committee. Membership will include representatives each from the relevant specialties who are active members of the Medical Staff; There is also representation from Nursing, Quality Management Risk Management, and ad hoc clinical representation.
- C. Frequency of Meetings: As needed.
- D. Responsible to: Medical Staff Executive Committee, Hospital Leadership Team, Women and Infants Quality Committee and appropriate department chief(s).

Section 5. Graduate Medical Education Committee

- A. Purpose: This Committee shall have the responsibility for monitoring all aspects of House Staff education and advising the Medical Staff Executive Committee and, through the Medical Staff Executive Committee, the Board of Directors. The Committee shall regularly communicate with the Medical Staff Executive Committee about the safety and quality of patient care provided by, and the

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related educational and supervisory needs of, House Staff in the program. It shall periodically review all graduate medical education programs at the Hospital for conformity to national and institutional standards of excellence.

- B. The functions of the Committee shall include, but shall not be limited to:
- Establishing and implementing GME policies;
 - Establishing and maintaining appropriate oversight of and liaison with program directors;
 - Regular review of all residency programs to assess their compliance with both the Institutional Requirements and Program Requirements of the relevant ACGME RRCs and requirements of the Joint Commission;
 - Assuring that each department with a residency or fellowship program establishes and keeps up to date written descriptions in its' departmental policy manual of the role, responsibilities, and patient care activities of House Staff, including levels of required supervision and each House Staff member's progressive involvement and independence in patient care responsibilities;
 - Making recommendations on the appropriate funding for House Staff positions;
 - Monitoring the programs to assure an appropriate work environment and duty hours; and
 - Monitoring residency program curriculum.
- C. Composition: The Director of Medical Education will chair the Committee. Members shall include the Program Directors or designees of ACGME-approved residency programs in the Hospital, Program Directors or designees from other residency programs sponsored by the Hospital, a representative of each Active Clinical Department, a representative each from Administration and Quality Management, physician representatives appointed by the President of the Medical Staff, and House Staff members nominated by their peers from each of the ACGME-approved programs and other residency programs sponsored by the Hospital. The Director of Medical Education from Rhode Island Hospital or a designee shall also serve on the Committee. All Committee members will have voting privileges.
- D. Frequency of Meetings: Quarterly and at the call of the Chair
- E. Responsible to: Medical Staff Executive Committee

Section 6. Continuing Medical Education Committee

- A. Purpose: This Committee shall be responsible for the oversight of Hospital-sponsored CME activities for their compliance with the standards of the Rhode Island Medical Society and the Essentials and Standards established by the Accreditation Council for Continuing Medical Education. This Committee shall be responsible for providing quality CME programs that are responsive to the needs of the Medical Staff and relevant to physicians' health and medical care activities.
- B. Composition: The Committee shall include representatives from the physician staff, the library, media services, and Hospital administration. The Director of Medical Education shall chair this committee.
- C. Frequency of Meetings: Quarterly and at the call of the Chair
- D. Responsible to: Medical Staff Executive Committee

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Section 7. Institutional Review Board

- A. Purpose: The Institutional Review Board shall review all research projects: to determine their compatibility with institutional goals and directions, to insure the availability of Hospital resources to honor the project's commitments, to document scientific merit, and to assure that subjects rights are protected and that the project is in compliance with applicable law. Each research protocol, which in any way involves the patients or resources of the Hospital, shall be approved by the Institutional Review Board. No research protocol may receive funding from an outside agency without the prior approval of the Institutional Review Board. Approved projects shall be sent to Administration for final disposition. The Institutional Review Board shall have an ongoing responsibility to monitor the progress of research in order to assure that it is consistent with approved protocols. Special attention shall be paid to the investigators' safeguards for the protection of human subjects.
- B. Composition: Institutional Review Board #1 shall include at a minimum three representatives from the Active Clinical Departments, the Director of Medical Education, three other appointees of the Medical Staff, a representative from Administration, and non-physician and non-scientific members as appropriate, including two non-Hospital related members. Pro-tem members may be appointed by the Institutional Review Board Chair to evaluate projects requiring specific expertise. In accord with Federal Regulations (21 CFR 56.107 and 45 CFR 46107) the Institutional Review Board shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members including consideration of race, gender, cultural backgrounds and sensitivity to such issues as community attitudes to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. The members should include persons knowledgeable about institutional commitments and regulations, applicable law and standards of professional conduct. The Institutional Review Board Chair shall be appointed by the President of the Medical Staff Association.

If the Institutional Review Board #1 is to review studies involving prisoners and if no Institutional Review Board #1 member has the specified qualifications set forth for an appropriate prisoner representative in Federal Regulations (45 CFR 46.304), the Institutional Review Board Chair has the discretion to call upon the formation of a second Institutional Review Board which would consist of the regular membership appointed by the President of the Medical Staff Association plus a specific prison representative who meets these qualification. This second Institutional Review Board would be referred to as Institutional Review Board #2. The prison representative would not be required to attend meetings of the Institutional Review Board #1. Studies involving prisoners are not common, but reviewing all aspects of studies from the time of initial review through amendments, continuing review and closure are necessary. Institutional Review Board #2 would address the needs of investigators, special representatives and prisoners. It would allow the Institutional Review Board to be in compliance with Federal regulations regarding vulnerable populations.

Other vulnerable populations identified in Titles 21 (21 CFR 56.107) and 45 (45 CFR 46 subparts B, C, and D) are pregnant women, human fetuses, neonates, children, and the mentally disabled. If there were a situation in which the Institutional Review Board #1 was not composed to review studies involving the mentally disabled, a similar process of convening an additional Institutional Review Board would be followed.

The additional Institutional Review Board(s), if required, would allow the Institutional Review Board to comply with specific Federal regulations and guidance. The additional Institutional Review Board(s) would allow Institutional Review Board #1 to meet its responsibilities and function with a dependable quorum.

- C. Frequency of Meetings: One to two meetings per month and at the call of the Chair

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- D. Provides Reports to: The Institutional Review Board shall function as an institutional review board of the Hospital in accordance with Federal regulations but shall provide reports to the Medical Staff Executive Committee.

Section 8. Nominating Committee

- A. Purpose: The Nominating Committee shall nominate Medical Staff Association officers every two years.

They shall nominate annually a member for the Credentials Committee, and members-at-large for the Medical Staff Executive Committee.

The Nominating Committee shall offer at least one nominee for each available position. Nominations must be announced, and the names of the nominees distributed to all members of the Active Staff at least thirty (30) days prior to the election.

A petition signed by at least 51% of the appointees of the Active Staff may add nominations to the ballot. Such a petition must be submitted to the President of the Medical Staff Association at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating Committee must determine if the candidate meets the qualifications stated in Article VIII before he or she can be placed on the ballot.

- B. Composition: This Committee shall consist of five appointees of the Active Staff. Two shall be appointed by the President of the Medical Staff Association and three shall be elected by the Medical Staff Association from the general membership of the Medical Staff Association. The Chair shall be appointed by the President of the Medical Staff Association.
- C. Frequency of Meetings: Annually and at the call of the Chair
- D. Responsible to: Medical Staff Association

Section 9. Bylaws Committee

- A. Purpose: The Bylaws Committee shall review the Medical Staff Association Bylaws as set forth in Article XII of these Medical Staff Association Bylaws and may propose amendments and modifications to them. The Bylaws Committee shall also consider all proposed new Medical Staff Association Bylaws and proposed amendments to existing Medical Staff Association Bylaws submitted by the Medical Staff Executive Committee and other Medical Staff appointees, for the purpose of reporting any duplication or inconsistency which might result from their adoption. All proposed new or amended Medical Staff Association Bylaws or amendments thereto shall be transmitted to the Chair of the Bylaws Committee for Committee recommendations. Bylaws Committee recommendations shall be acted upon by the Medical Staff Association.
- B. Composition: The President of the Medical Staff Association shall appoint a Chair, five Medical Staff appointees with admitting privileges from Active Clinical Departments and one member of the Hospital administration, Legal Counsel, and Risk Management.
- C. Frequency of Meetings: At least one meeting will be held annually. Other meetings may be held at the call of the Chair.

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D. Responsible to: Medical Staff Association

Section 10. Bioethics Committee

A. Purpose: The purpose of the Bioethics Committee of the Hospital is to assist the Medical Staff, Administration, patients and families by serving as a mechanism for:

- (1) The development, recommendation, and review of broad institutional standards, policies and procedures related to bioethical issues;
- (2) Interdisciplinary dialogue concerning the bioethical implications of patient care and medical research and for the review of individual cases including, but not limited to, those in which a decision regarding the termination or withholding of life-sustaining treatment is involved; and
- (3) The promotion of related educational activities.

The Bioethics Committee will maintain minutes of all of its meetings and discussions. In those instances in which the Committee considers an individual patient management issue a brief summary note may be made in the patient's medical record, by an Attending Physician or by an appropriate appointee of the AHP Staff to the extent permitted by Hospital policy and consistent with the AHP Staff appointee's scope of practice under his or her state license, of the Committee's involvement and discussion.

B. Composition: The Chair, who shall be an appointee of the Medical Staff, and members, will be appointed by the President of the Medical Staff.

Representation will be as follows:

- 2 - Medical Staff OB/GYN appointees (upon the recommendation of the chief of the department)
 - 2 - Medical Staff Pediatric appointees (upon the recommendation of the chief of the department)
 - 1 – Neonatologist appointee
 - 2 – Medical Staff appointees (in addition to OB/GYN and Pediatric appointees)
 - 1 - Member of Nursing (upon the recommendation of Administration)
 - 1 - Member of Social Service (upon the recommendation of Administration)
 - 1 - Bioethicists/Clergyman (upon the recommendation of Administration)
 - 1 - Attorney (upon the recommendation of Administration)
 - 3 - Community Representatives (upon the recommendation of Administration)
 - 1 - Member from Hospital administration
- It shall also include, upon invitation, other consultants or guests as needed, at the direction of the Chair

C. Frequency of Meetings: Quarterly and at the call of the Chair. Additional meetings will take place upon the request of a member of the Bioethics Committee, the Attending Physician, member of the medical team, the patient or the patient's family. The Committee will consider such decisions only within the framework of established institutional policies and procedures.

D. Responsible to: Medical Staff Executive Committee

Section 11. Medical Staff Association Professional Health Committee

A. Purpose: The Professional Health Committee shall be the mechanism for dealing with Medical Staff appointees who exhibit behavior which raises the possibility of compromised patient care. The

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Committee will function in accordance with the Medical Staff Policy on the Professional Health Program. The committee shall be a peer review committee and will function under the provisions of the Health Care Quality Improvement Act of 1986.

- B. Composition: The membership of the Professional Health Committee shall consist of four Active Staff appointees, in good standing, none of whom may be members of the Board of Directors, Medical Staff Executive Committee or Credentials Committee, or hold the position of division director or department chief. One member shall be designated as the Chair and serve as a member of the Rhode Island Medical Society Physicians Health Committee. One member from Hospital administration will also be a member. The President of the Medical Staff Association shall appoint the members for terms of office renewable without limit.
- C. Frequency of Meetings: At the call of the Chair
- D. Responsible to: President of the Medical Staff, Administration, appropriate department chief, and Hospital Risk Manager
- D. Reporting: Annual Report to Medical Staff Executive Committee

Section 12. Medical Records Committee

- A. Purpose: The Medical Records Committee shall be the mechanism for reviewing and approving the structure and format of the documents and forms that comprise the paper and electronic medical record at the Hospital and associated practices. The Committee will function in accordance with the Medical Staff Bylaws and other policies pertaining to the medical record.
- B. Composition: The membership of the Medical Records Committee shall consist of three physicians on the Active Medical Staff, in good standing, none of whom may be members of the Board of Directors or hold the position of division director or department chief. One Medical Staff member shall be designated as the Chair. Committee members from Hospital Administration include the Director or designees from Health Information Management, Risk Management, Quality Improvement, Pharmacy and Clinical Informatics. The President of the Medical Staff shall appoint the Medical Staff members for terms of office renewable without limit.
- C. Frequency of Meetings: Monthly or at the call of the Chair
- D. Responsible to: Medical Staff Executive Committee
- E. Reporting: Monthly Report to Medical Staff Executive Committee

Section 13. Special Committees

Special committees may be appointed from time to time by the President of the Medical Staff Association to perform special tasks for the Hospital. Such committees shall confine their work to the purpose for which they were appointed and shall report to the Medical Staff Executive Committee.

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**ARTICLE X
MEDICAL STAFF MEETINGS**

Section 1. Regular Meetings

Regular meetings of the Medical Staff Association shall be held at least twice per year.

Section 2. Annual Meetings

The last meeting in the calendar year of Medical Staff Association shall be designated as the Annual Meeting of the Medical Staff Association. At this meeting the retiring officers and Committees shall make such reports as may be desirable, and the officers for the ensuing year shall be elected, as well as required Medical Staff Committee members.

Section 3. Special Meetings

Special meetings may be called at any time by the President of the Medical Staff Association and shall be called at the request of the Board of Directors, Medical Staff Executive Committee, or by five appointees of the Active Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting.

Section 4. Notice of Meetings

Notice of meetings shall be posted on the bulletin board in the Staff Room and reasonable attempt shall be made to notify the voting appointees of the Medical Staff at least 72 hours before the meeting.

Section 5. Attendance at Meetings

All categories of the Medical Staff are encouraged to attend all regularly scheduled Medical Staff Association meetings.

Section 6. Quorum

Ten voting appointees of the Medical Staff shall constitute a quorum.

Section 7. Voting

Voting privileges shall be limited to appointees of the Active Staff.

**ARTICLE XI
COMMITTEE MEETINGS**

Section 1. Regular Meetings

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

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Section 2. Special Meetings

A Special Meeting of any committee may be called by or at the request of the Chair, by the President of the Medical Staff Association, or by one-third of the group's members, but not less than two members.

Section 3. Notice of Meetings

A three-day written or 24-hour oral notice stating the place, day, and hour of any special or regular meeting, not held pursuant to resolution, shall be given to each member of the committee by the person or persons calling the meeting.

Section 4. Quorum

At any meeting no less than two Active Staff appointees shall constitute a quorum.

Section 5. Manner of Action

The action of a majority of the members present at a meeting shall be the action of a committee. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote.

Section 6. Rights of Ex-Officio Members

Persons serving under these Medical Staff Association Bylaws as ex-officio members of a committee shall have all rights and privileges of regular members.

Section 7. Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of attendance and action taken.

The minutes shall be signed by the presiding officer and forwarded to the appropriate committee for further action. Each committee shall maintain a file of the minutes of each meeting in accordance with Hospital and Medical Staff policies.

Section 8. Attendance Requirements

Active Staff appointees may be excused from such meetings by notifying the committee chairman thereof the reason for such absence.

**ARTICLE XII
AMENDMENTS**

These Medical Staff Association Bylaws shall be amended when necessary to reflect the current practices with respect to Medical Staff organization and function.

Upon approval of the Medical Staff Executive Committee, these Medical Staff Association Bylaws may be amended at any meeting of the Medical Staff Association provided the amendment has been submitted to the voting members of the Medical Staff **seven (7)** days prior to the call of the meeting. Such an amendment shall require a two-thirds majority of those appointees present and voting for adoption. Amendments so made shall be effective when approved by the Board of Directors. The Bylaws Committee and the Medical Executive Committee may recommend amendments to the Medical Staff

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rules, regulations and policies. The Medical Staff Association also has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the Board of Directors. If the voting members of the Medical Staff Association propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the Medical Executive Committee. If the Medical Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff. When the Medical Executive Committee adopts a policy or an amendment thereto, it communicates this to the Medical Staff.

Upon approval by the Board, the approved changes are communicated to the Medical Staff via a monthly report (sent by email) and are also listed on the Medical Staff Services website.

**ARTICLE XIII
RULES OF ORDER**

The current edition of "Robert's Rules of Order" shall be the Medical Staff Association's parliamentary authority, unless special rules of order are adopted to supplement or modify rules contained in the above named edition.

Exhibit 44D

Medical Staff Rules and Regulations, dated 7/23/2020.
 Description of Credentials Committee and Point System

H. Medical Staff Committees

Unless otherwise specifically noted in the descriptions of Medical Staff Committees located in the Bylaws and these Medical Staff Rules and Regulations, each committee meets at least on a quarterly basis and a permanent record made of its proceedings and actions which is forwarded to the Medical Executive Committee. Committee chairs may call additional meetings as necessary. The Medical Staff President appoints the committee chair. The Committee Chair may appoint the members in consultation with the President. The Medical Staff President and the Chief Medical Officer or their designee(s) are ex-officio member of each Medical Staff Committee with vote. A quorum consists of 40% of the voting members, but no fewer than three members.

1. The Credentials Committee

- A. Composition: This Committee consists of the Chair and at least four members of the medical staff and at least one Advanced Practice Professional.
- B. Duties:
 - (1) Review the completed Applications for Appointment to the Medical Staff and clinical privileges, interview applicants and make recommendations to the Medical Executive Committee with regard to appointment.
 - (2) Review the completed Applications for Reappointment to the Medical Staff and clinical privileges and make recommendations to the Medical Executive Committee with regard to appointment.
 - (3) Review the Focused Professional Practice Evaluation (FPPE) process and completed forms, making recommendations to the Medical Executive Committee
 - (3) Draft, review and propose revisions to Medical Staff Policies, Procedures and forms that relate to the credentialing process.
 - (4) Recommend changes to the credentialing process, as necessary

I. Point System

At time of reappointment (at least every two years), medical staff members are assigned their staff status according to the following Point System.

DESCRIPTION OF POINTS NEEDED IN A TWO-YEAR PERIOD		MINIMUM POINTS
ACTIVE HOSPITAL	ADVANCEMENT TO ACTIVE - Must include five (5) points for patient activity and at least 2 medical staff activity points	7 points
	MAINTENANCE - Must include five (5) points for hospital patient activity and at least 4 medical staff activity points	9 points
ACTIVE COMMUNITY	Must include at least four (4) points for patient activity	4 points
AFFILIATE	Must include at least four (4) points for medical staff activity	4 points

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Description of Credentials Committee and Point System

DESCRIPTION OF POINTS NEEDED IN A TWO-YEAR PERIOD		MINIMUM POINTS
ADVANCED PRACTICE PRACTITIONER	Must include at least four (4) points for patient activity	7 points
CONSULTING	No points needed	0
PROVISIONAL	Maximum 12 months of initial appointment A physician may be assigned to another staff category as soon as the required patient and medical staff activity has been accumulated. Must have completed FPPE in order to move to any category except Active Community II.	
HONORARY	No points needed	0

ACCUMULATED POINTS

PATIENT ACTIVITY POINTS (prior two year period): Attending/Admitting physician, Partial Hospital physician, H&Ps, consultations 1-6 Patients = 2 points 7-12 patients = 3 points 13-23 = 4 points 24+ patients = 5 points	
SERVING AS A PROCTOR OR AN OBSERVER (FPPE): 1 case = 1 medical staff activity point (3 points maximum per year)	
COMMITTEE MEETING ATTENDANCE: (as a Committee member; Medical Staff or Butler Hospital Committee) 50% attendance per committee = 1 point (3 points maximum per year)	
COMMITTEE CHAIRMANSHIP (Medical Staff or Hospital Committee) 1 committee = 5 medical staff activity points (5 points maximum per year)	
BH STAFF ASSOCIATION MEETINGS: One point per meeting (4 point maximum per cycle)	
CME ACTIVITIES (sponsored by Butler Hospital): 1-3 hours/year = 1 medical staff activity point 4-6 hours/year = 2 medical staff activity points 7+ hours/year = 3 medical staff activity points (3 points maximum per year)	
SPEAKER AT BUTLER HOSPITAL CME ACTIVITY: Category 1 credit activity = 1 per lecture Community education lecture = 1 point per lecture (3 points maximum per year)	
HOSPITAL SERVICE: Participation in an intensive review/fact finding/special case review = 2 points per year	
CURRENT FACULTY APPOINTMENT at Brown University (1 point)	
SUPERVISION OF PHYSICIAN ASSISTANT STUDENTS, ADVANCED PRACTICE NURSING STUDENTS, MEDICAL STUDENTS AND/OR RESIDENTS Supervision must be for the care of Butler Hospital patients One point per student/resident (3 points maximum per cycle)	
COMMUNITY SERVICE (2 points maximum per cycle) Appointment to State Health Care-related Committees (1 point) Donation of time at free clinics (1 point)	
CARE NEW ENGLAND (excluding Butler) Activity Committee member (1 point per Committee) (3 points maximum per cycle)	
BROWN UNIVERSITY / ALPERT MEDICAL SCHOOL COMMITTEE ACTIVITY / Lectures to Residents Committee member (1 point per Committee/Lecture) (3 points maximum per cycle)	

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ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

Section 1. General Provisions.

- A. Assignment. Each Medical Staff member is assigned to a Medical Staff category defined in this Article. Members of each Medical Staff category have the prerogatives and carry out the duties defined in these Bylaws and the Medical Staff Rules and Regulations, Policies and Procedures. Action may be initiated to change the Medical Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in these Bylaws and Rules and Regulations. Changes in Medical Staff category are not grounds for a hearing unless they adversely affect the Medical Staff member's clinical privileges.
- B. Point System. Members shall meet the requirements of the Point System for their respective categories as included in the Rules and Regulations. This system was established whereby activity of the Medical Staff member determines the category for which s/he qualifies. Points are accrued based upon this activity. A predetermined number of points are required to remain in or advance to a specific Medical Staff category.
- C. Qualifications. All Medical Staff members must first meet the Qualifications for Membership as set out in ARTICLE V - APPOINTMENTS TO THE MEDICAL STAFF. All Medical Staff members are eligible to participate in medical staff committees; however, if the member is other than Active Staff, s/he may vote on committee matters if the right to vote is specified at the time of appointment to such committee. Radiologists, anesthesiologists and Consulting Staff members are not eligible to be granted admitting privileges.
- D. All members of the Medical Staff shall obtain Board certification in accordance with the specialty certification requirements of the appropriate ABMS Board, or equivalent certifying body, and in accordance with these Bylaws. In the event a member has been issued a time limited specialty or subspecialty Board certification, recertification must be obtained in accordance with the requirements established by the appropriate ABMS Board, or equivalent certifying body.

Section 2 - Active Hospital Staff

- A. Active Hospital Staff members are regularly involved in the care of patients in the Hospital, inpatient and/or outpatient, who, except for good cause, have satisfactorily completed the provisional period.
- B. Active Hospital Staff members assume all medical staff functions and responsibilities including, where appropriate, serving on committees and voting on matters before those committees, voting on matters before the organized medical staff, completing observation and/or proctoring assignments (FPPE), serving as physician reviewers, holding office in the medical staff organization.
- C. Active Hospital Staff members may request clinical privileges.

Section 3 - Active Community Staff & Affiliate Staff

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A. Active Community Staff

- (1) Medical Staff members who are unable to accumulate a sufficient number of points to move into the Active Hospital Staff category, but who care for patients on a part-time or weekend basis.
- (2) Active Community Staff members may request clinical privileges.
- (3) Active Community Staff members are not eligible to hold office, but may serve on committees, vote on matters before the organized medical staff, and may complete observation and/or proctoring assignments (FPPE).

B. Affiliate Staff

- (1) Affiliate Staff are those Practitioners who do not exercise clinical privileges, but accumulate medical staff activity points
- (2) Affiliate Staff members are not eligible to request clinical privileges.
- (3) Affiliate Staff members are not eligible to hold office, but may serve on committees, and vote on matters before such committees.

Section 4 – Consulting Staff

- A. Consulting Staff members are those Practitioners who are on the medical staff specifically because of their subspecialty and ability to render a consultation when requested by a Medical Staff member.
- B. Consulting Staff members may request clinical privileges and may serve on committees, but are not eligible to assume any other medical staff functions and responsibilities, including holding office or voting, due to the limited nature of their membership.

Section 5 - Honorary Staff

- A. Honorary Staff are Practitioners who have been a member of the Medical Staff for at least ten years and have had significant involvement with the Hospital and/or medical staff, as determined by the Medical Executive Committee, but who no longer participate in Hospital activities due to retirement or disability.
- B. Honorary Staff members may attend medical staff meetings and CME activities, and may serve on medical staff committees. Honorary Staff members are not eligible to request clinical privileges, hold office or vote.

Section 6 – Provisional Staff

- A. Immediately prior to application and appointment, Provisional Staff members were not, or were no longer, Medical Staff members.
- B. Provisional Staff members are eligible to request clinical privileges.
- C. Provisional Staff members assume medical staff functions and responsibilities as requested by the President (or his/her designee) including, but not limited to, serving on committees.
- D. Provisional Staff members may not hold office or vote.
- E. New Medical Staff members remain on the Provisional Staff up to 12 months, but may be considered for an extension of Provisional Staff status if he/she has earned at least two medical

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staff points. Before the expiration of this 12 month period, the reappointment process will be completed, with the Provisional Staff member's activity quantified and an assignment made to the applicable Medical Staff Category. If the Provisional Staff member has accumulated no points, s/he is no longer eligible for membership on the medical staff.

Section 7 – Advanced Practice Professionals

- A. For purposes of these Bylaws, Advanced Practice Professionals are limited to APRN/Nurse Practitioners and Physician Assistants who have met all of the qualification set forth for Medical Staff membership and clinical privileges.
- B. Advanced Practice Professionals are regularly involved in the care of patients in the Hospital, inpatient and/or outpatient, who, except for good cause, have satisfactorily completed the provisional period.
- C. Advanced Practice Professionals members assume all medical staff functions and responsibilities including, where appropriate, serving on committees and voting on matters before those committees, voting on matters before the organized medical staff, and completing observation and/or proctoring assignments (FPPE).
- D. Advanced Practice Professionals members are eligible to request clinical privileges.
- E. Advanced Practice Professionals may not hold office.

Section - 8 - Emergency Privileges

In the case of an emergency, any Medical Staff member, to the degree permitted by his/her license and regardless of staff status or lack thereof, shall be permitted to do everything possible to save the life of a patient, except as limited by any Advance Directive and in accordance with Hospital policy, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, the patient shall be assigned to the care of an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section - 9 - Disaster Privileges

- A. When the disaster plan has been implemented and the immediate needs of the patients cannot be met, the Hospital may implement a modified credentialing and privileging process for eligible volunteer practitioners in accordance with Hospital policy. For details of credentialing volunteers, refer to the Butler Hospital Policy and Procedure, Medical Staff, "Credentialing Individuals in the Event of a Disaster", which by reference is incorporated herein.
- B. The option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the Hospital and its patients, and on the qualifications of its volunteer practitioners. If it is determined that additional medical staff are needed to address immediate patient care needs, the President/COO or President or their designees may grant disaster privileges at his/her discretion per policy.

Section 10 - Temporary Privileges

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- A. There are two (2) circumstances in which temporary appointment and privileges can be granted. Each circumstance has different criteria for granting appointment and privileges.
1. Temporary appointment and privileges can be granted on a case by case basis when a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Governing Body for a period not to exceed one hundred and twenty (120) days. A complete application must be processed in accordance with the full credentialing procedure for appointment and privileges as specified in Article V. If the above conditions are met, the process of approval may be accelerated, as described below in Paragraph B in this Section. A completed application that raises no concerns and is awaiting approval by the Governing Body may be approved following the Expedited Credentialing Policy.
 2. Temporary appointment and privileges can also be granted on a case by case basis when there is an important patient care, treatment and service need that mandates an immediate authorization to practice, for a period not to exceed one hundred and twenty (120) days in any one (1) year period. Temporary appointment and privileges cannot be granted in more than two (2) consecutive years. An important patient, care, treatment or service need includes, but is not limited to the following circumstances:
 - a. An individual who has been granted clinical privileges at Butler Hospital is suddenly incapacitated
 - b. There is an urgent clinical need for a specialist and there is no practitioner who retains privileges in that clinical specialty
 - c. Temporary privileges may not be used on a routine basis for any delay in the credentials or administrative procedures, except if a practitioner's appointment and privileges are expiring and failure to allow the practitioner to continue to provide care would result in compromising patient care. This scenario might include a staffing shortage and/or placing an undue burden on other practitioners' caseloads.
- B. The CMO (or his/her designee) may upon the basis of information available which may reasonably be relied upon as to the competence and ethical standing of the applicant, with the written concurrence of the President and the President/COO or his/her designee, grant temporary provisional admitting and clinical privileges to the applicant for a period not exceeding 120 days in accordance with Medical Staff policy. If temporary privileges are warranted due to an important patient care need, the CMO (or his/her designee) will identify what the important patient care need is in writing and place it in the applicant's file.

Section 11 - Professional Liability Insurance

- A. All Medical Staff members, Allied Health Professional Staff, and applicants for appointment or reappointment (except to Honorary Staff) must be insured for professional liability in such amounts as the Staff Association from time-to-time determines, with the approval of the Governing Body.
- B. Applicants for appointment or reappointment must report any involvement in a professional liability action(s) as yet unresolved and any final judgment(s) or settlement(s) involving the applicant as set forth in the appointment process of these Bylaws, Article V, Section 3.A.1 and Article V, Section 3.D.2.

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Section 12 – Leave of Absence

- A. A leave of absence is intended to provide a mechanism by which a Practitioner may temporarily leave the area and/or active practice without undergoing a full credentialing process upon returning to practice. A leave of absence will not be approved for members remaining in active practice in the area or remaining on the medical staff of another area hospital.
- B. At the discretion of the Medical Executive Committee, Practitioners and Allied Health Professionals may obtain a leave of absence for cause from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed the expiration date of his current appointment. During the leave, the member will not exercise clinical privileges at the Hospital, and his/her membership rights and responsibilities are inactive, but his/her obligation to pay dues, if any, will be met at the time of his/her request for reinstatement. The Medical Executive Committee on a case-by-case basis considers any written request for extension of a leave of absence.
- C. At least ninety (90) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff or Allied Health Professional Staff member may request reinstatement of his/her privileges by submitting a reappointment application to the Medical Staff Services Office. The staff member submits a written summary of relevant activities during the leave, and other information as requested. The reappointment application is processed according to Article VI, Section 3. The credentials committee may recommend re-institution of proctoring and/or observation for any or all requested clinical privileges.
- D. Failure, without good cause, to request reinstatement or to provide requested information will be considered a voluntary resignation from the Medical or Allied Health Professional Staff and result in automatic termination of membership and privileges. The Practitioner or Allied Health Professional whose membership is automatically terminated is not entitled to the procedural rights provided in Article IX. A request for Medical Staff or Allied Health Professional Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.
- E. Military Leave of Absence: If the Medical Staff or Allied Health Professional Staff member requests a leave of absence to fulfill military obligations, and if there are fewer than 24 months until the expiration of his current appointment, the Medical Staff or Allied Health Professional Staff member shall be asked to complete a reappointment application so that he may be granted a full two year leave of absence. If the Medical Staff or Allied Health Professional Staff member has not completed his military obligation at the end of the current appointment, the Medical Executive Committee may recommend to the Governing Body that the member be reappointed for Medical Staff or Allied Health Professional Staff membership only up to another 24 months. At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of his privileges by submitting a reappointment application to the Medical Staff Services Office. If the duration of the leave of absence is more than 24 months, the medical staff member shall be reappointed to the Provisional Staff and his request for clinical privileges shall be subject to the usual and customary proctoring and observation process.

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Section 13 – Dues

Payment of staff dues is a condition of reappointment. Members of the Medical Staff shall pay annual dues which are payable by the end of December. Dues are delinquent if not paid by January 1st at which time a certified letter, return receipt requested, will be sent to all members whose dues are delinquent notifying them that all privileges will be suspended in ten (10) days and remain suspended until this deficiency is corrected, not to exceed March 1st or sooner if the Practitioner's appointment or reappointment ends prior to March 1st. A practitioner shall not be reappointed to the Medical Staff if staff dues have not been paid. If delinquent dues are not paid by March 1st, the Practitioner shall be deemed to have voluntarily resigned as of that date. Honorary Staff members are not required to pay dues. A Practitioner who resigns in such manner is not entitled to procedural rights as outlined in Article VIII.

ARTICLE V - APPOINTMENTS TO THE MEDICAL STAFF

Section 1 - Qualifications for Appointment

Only Practitioners and Allied Health Professionals licensed to practice in the State of Rhode Island, and who can document their background, experience, training and demonstrated competence, current licensure, their adherence to the ethics of their profession, their good reputation, their physical and mental health status, and their ability to work with others with sufficient adequacy to assure the Medical Staff Association of Butler Hospital and the Governing Body that any patient treated by them in the Hospital shall be given a high quality of medical care, and are qualified for membership on the Medical Staff or Allied Health Professional Staff.

Section 2 - Conditions and Duration of Appointment

- A. Initial appointments and reappointments to the Medical Staff and Allied Health Professional are made by the Governing Body. The Governing Body acts on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Executive Committee as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Executive Committee the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's professional and ethical qualifications obtained from reliable sources other than the Medical Staff. For the purposes of this Section, unwarranted delay generally means 120 days from the date that the fully completed application has been received by the Medical Staff Services Office.
- B. All initial appointments are provisional for at least one calendar year (i.e., initial appointment is to the Provisional Staff category of the Medical Staff or Allied Health Professional Staff). Subsequent reappointments are for a period of not more than two years
- C. Every appointment to the Medical Staff and Allied Health Professional Staff shall be conditioned on the Practitioner's or Allied Health Professional's obligations to provide continuous care and supervision of his/her patients; to abide by the Bylaws and Rules and Regulations of the Medical Staff, Medical Staff and Hospital policies and procedures and Hospital Bylaws as they relate to the medical staff matters; to accept assignment to committees of the Staff Association; to accept consultation assignments; and to maintain membership in good standing on the Medical Staff or Allied Health Professional Staff.

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- D. By applying for appointment to the Medical Staff or Allied Health Professional Staff or accepting an appointment to the Medical Staff or Allied Health Professional Staff, each Practitioner and Allied Health Professional thereby:
1. signifies his willingness to appear for interviews in regard to his/her application for continued appointment or reappointment;
 2. authorizes the Hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her current competence, clinical judgment, training and experience, health status, character, ethical qualifications and licensure;
 3. consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications, current competence, clinical judgment, training, experience, licensure and health status to carry out the clinical privileges as well as his/her moral and ethical qualifications for staff membership;
 4. releases, to the fullest extent permitted by law, from any and all liability the Hospital, all representatives of the Hospital and members of the Medical Staff and Allied Health Professional Staff, for their acts performed in good faith in connection with evaluating the applicant and his/her credentials;
 5. and releases from any liability all individuals and organizations who provide information to the Hospital in good faith concerning the applicant's competence, training, health status, licensure, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

Section 3 - Procedure for Appointment and Reappointment

A. Application for Appointment

1. All initial applications for appointment to the Medical Staff or Allied Health Professional Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Medical Executive Committee. The application shall require detailed information concerning the applicant's professional qualifications, shall include the name of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence, clinical judgment, training and experience, character, ethics, health status and other qualifications and ethical character; shall include information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, or not renewed, voluntarily or involuntarily, at any other hospital or institution; shall include information as to whether his/her membership in local, state, or national medical societies has been terminated voluntarily or involuntarily; shall include information as to whether there are or have been any previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary or involuntary relinquishment of such licensure or registration; shall include a report of any involvement in a professional liability action as yet unresolved and any final judgment(s) or settlement(s) involving the applicant; and shall include a statement as to the applicant's mental and physical health status during the past five years.

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2. The applicant has the burden of producing adequate information for proper evaluation of his/her competence, clinical judgment, training and experience, current licensure, character, ethics, health status and other qualifications, and for resolving any doubts about such qualifications.
3. The completed application shall be submitted to the Medical Staff Services Office. A completed application shall include a completed application form, copies of the applicant's current state licensure (R.I. medical license and any other state license which is currently active), current DEA licensure, R.I. controlled substance license (if applicable), Board certification, medical school degree, certificates of completion of internship/residency and fellowship programs, ECFMG (if applicable), current malpractice certificate of coverage, a curriculum vitae in the proscribed format, a signed Release/Immunity Statement, a signed Authorization for Release of Insurance Statement, a signed code of ethics statement, and an application fee in such amount as is from time-to-time determined by the Staff Association with the approval of the Governing Body. After collecting the references and other materials deemed pertinent, the Medical Staff Services Office transmits the application and all supporting materials to the Credentials Committee for evaluation.
4. The application form shall include a statement that the applicant has received and read the Bylaws and Rules and Regulations of the Medical Staff, Medical Staff and Hospital policies and procedures and Hospital Bylaws as they relate to the Medical Staff, and that the applicant agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application. Moreover, it shall include a statement that the applicant pledges himself/herself to ethical standards of professional conduct, pledges to provide for continuous care for his/her patients; and acknowledges any provisions for release and immunity from civil liability.

C. Appointment Process

1. Within 120 days after receipt of the completed application for membership, the Credentials Committee makes a written report of its investigation to the Medical Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, training, health status, current licensure, qualifications and ethical standing of the individual and shall determine his/her qualifications through information contained in references given by the individual and from other sources available to the Committee. Together with its report, the Credentials Committee transmits to the Medical Executive Committee the completed application and recommendation that the individual be appointed as a member of the Medical Staff or Allied Health Professional Staff and granted the privileges requested, that the application be deferred for further consideration, or that the application be denied.
2. The Medical Executive Committee reviews and makes a recommendation as to whether or not the individual should be appointed to the Medical Staff or Allied Health Professional Staff in the appropriate category and granted the privileges requested, if he/she should be rejected for Medical Staff or Allied Health Professional Staff membership, or if his/her application should be deferred for further consideration. If the recommendation of the Medical Executive Committee is that the individual not be granted the clinical privileges requested, or that privilege limitations or qualifications be imposed, the conditions or limitations on his/her appointment are stated in the recommendation of that committee.

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3. The President or his/her designee presents the Medical Executive Committee report to the next meeting of the Credentials Committee of the Governing Body/Board of Directors of Care New England Health System (hereinafter referred to as “Board Credentials Committee”) for a recommendation as to whether or not the individual should be appointed to the Medical Staff or the Allied Health Professional Staff in the appropriate category and granted the privileges requested, if he/she should be rejected for Medical Staff or the Allied Health Professional Staff membership, or if his/her application should be deferred for further consideration.
4. A recommendation of the Board Credentials Committee to defer the application for further consideration must be followed within 90 days with a subsequent recommendation for appointment or for rejection for staff membership.
5. When the recommendation of the Board Credentials Committee is adverse to the applicant either in respect to membership or clinical privileges, the President shall promptly so notify the applicant by certified mail, return receipt requested. The letter will notify the applicant of his rights under Article VIII of these Bylaws.
6. A favorable recommendation of the Board Credentials Committee shall be transmitted to the Governing Body for further action pursuant to Section 3(E) of this Article.

D. Reappointment Process

1. Prior to the expiration of a Practitioner’s or Allied Health Professional’s reappointment, the Medical Executive Committee reviews all pertinent information available on each such Practitioner or Allied Health Professional for the purpose of determining its recommendations for reappointment to the Medical Staff or Allied Health Professional Staff and for the granting of clinical privileges for the ensuing reappointment period.
2. In addition to those criteria enumerated in Article V, Section 3(a) with respect to new applicants, each recommendation concerning the reappointment of a Medical Staff or Allied Health Professional Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients as demonstrated, in part, by findings of the Hospital Quality Assessment and Improvement Committee, his/her ethics and conduct, his/her physical and mental health, his/her current licensure, his/her attendance at Medical Staff meetings (if applicable) and participation in staff affairs, his/her compliance with the Medical Staff Bylaws and Rules and Regulations, his/her cooperation with Hospital personnel, his/her use of the Hospital's facilities for his/her patients, his/her relations with other practitioners, and his/her general attitude toward patients, the Hospital and the public. Any applicant for reappointment may be required to submit any reasonable evidence of current health status that may be requested by the Medical Executive Committee. Any applicant for reappointment will be required to provide to the Medical Executive Committee a report of any involvement in a professional liability action as yet unresolved and any final judgment(s) or settlement(s) involving the applicant since the last application for appointment or reappointment was submitted. Any applicant for reappointment will be required to provide to the Medical Executive Committee a report of any previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary or involuntary relinquishment of such licensure or registration; the voluntary or involuntary termination of medical staff membership; or the voluntary or involuntary limitation, reduction, or loss of clinical

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privileges at any hospital or institution since the last application for appointment or reappointment was submitted. Any applicant for reappointment to the Medical Staff or Allied Health Professional Staff pledges to provide for continuous care for his/her patients and acknowledges any provisions in these Bylaws for release and immunity from civil liability.

3. (i) Except as provided in (ii) below, at least fourteen (14) days prior to the final scheduled meeting of the Governing Body in the year in which the appointment expires, the Medical Executive Committee shall make written recommendations to the Governing Body concerning the reappointment, non-reappointment and/or clinical privileges of each Practitioner or Allied Health Professional. Where non-reappointment or a reduction in clinical privileges is recommended, the reasons for such recommendation shall be noted in the recommendation of said committee.
(ii) In the event of a recommendation of the Medical Executive Committee which is adverse to the reappointment or clinical privileges of the Practitioner or Allied Health Professional, the Practitioner or Allied Health Professional shall be notified by certified mail, return receipt requested, of his or her rights under Article VIII of these Bylaws, and such recommendation shall not be forwarded to the Governing Body until such rights have been exhausted or waived. Except in the event the Practitioner is under a Summary Suspension under Article VII, Section 2, or an Automatic Suspension under Article VII, Section 3, the appointment and privileges of the Practitioner or Allied Health Professional shall continue in effect pending completion (or waiver) of such hearing rights.

E. Actions by the Governing Body

1. Upon receipt of a favorable recommendation on appointments or reappointments, or following the completion or waiver of the Practitioner's or Allied Health Professional's rights under Article VIII, the Governing Body shall act upon such recommendation. Except as otherwise provided in these Bylaws, such decision shall be conclusive. The Governing Body may defer final determination by referring a matter concerning appointment or reappointment back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit by which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an inquiry be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the Governing Body shall make a decision.
2. If the decision of the Governing Body is adverse to the Practitioner either on appointment or clinical privileges, and the Practitioner has not waived or exhausted his or her rights under Article VIII of these Bylaws, the decision of the Board shall be held in abeyance until such rights are exercised or waived.
3. Whenever the Governing Body's decision will be contrary to the recommendation before it, and the Practitioner or Allied Health Professional has exhausted or waived his or her rights under Article VIII of these Bylaws, the Governing Body shall submit the matter to the Joint Conference Committee for review and recommendation and shall consider such recommendation before making its decision final.
4. When the Governing Body's decision is final, it shall send written notice of such decision through the President, to the Practitioner or Allied Health Professional.

Medical Staff Bylaws, dated 6/27/2019

Article IV – VI - Credentialing

Section 4. General Rules for Medical Staff or Allied Health Professional Appointment to this Hospital and another Care New England Health System (CNE) hospital (a “CNE Hospital”)

Practitioners desiring to exercise clinical privileges at this Hospital and another CNE Hospital are subject to the following provisions regarding dual application, appointment and reappointment:

- A. A single application form is used for applicants who wish to obtain membership and/or exercise clinical privileges at this Hospital and another CNE Hospital. The applicant indicates on the application form the facility where he desires to exercise clinical privileges.
- B. The applicant authorizes the Medical Staff Services Office to transmit the results of the information gathering and verification process, the application and all supporting materials to Medical Staff Services Office of the applicable CNE Hospital(s).
- C. Upon the transfer of such information to the Medical Staff Services Office of the applicable CNE Hospital(s), each CNE Hospital complies with its individual Bylaws, Rules and Regulations, and policies as it relates to processing of such information.
- D. Such information is then processed in this Hospital in accordance with these Bylaws.

ARTICLE VI - ALLIED HEALTH PROFESSIONAL STAFF

- A. Professionals who are qualified to exercise independent clinical judgment in the assessment and treatment of outpatients, patients being admitted, or research subjects, but who are not members of the Medical Staff may be granted delineated clinical privileges via privilege forms
- B. Specific clinical privileges may be granted to Allied Health Professionals, so long as the clinical privileges are commensurate with the training and experience of the Allied Health Professional. Each Allied Health Professional must agree to abide by these Bylaws, the Rules and Regulations, the Medical Staff Policies and Procedures and the policies and procedures and bylaws of the Hospital. The status, clinical duties, and responsibilities of all such Allied Health Professionals and the role of each in the care of inpatients, residential patients, partial/day patients, outpatients and research subjects, shall be delineated by the CMO in consultation with the Medical Executive Committee.
- C. Clinical privileges are granted on an individual basis. Privilege forms are developed in collaboration with the Chief or Director of the relevant discipline and are to be approved by the Medical Executive Committee and the Governing Body.
- D. Any applicant or member of the Allied Health Professional Staff who has been terminated, excluded or precluded by government action from participation in Medicare, Medicaid or any other federal health care program is ineligible for appointment or reappointment until such time as the applicant or member of the Allied Health Professional Staff is fully eligible to participate in Medicare, Medicaid and all other federal health care programs.
- E. Allied Health Professional applications are processed following the Medical Staff credentialing and privileging process as outlined in ARTICLE V.

Exhibit 44E

**RESOLUTION OF
THE BOARD OF TRUSTEES OF THE RHODE ISLAND HOSPITAL
RELATING TO
PRACTITIONER CREDENTIALING
DURING THE COURSE OF THE COVID-19 PANDEMIC**

WHEREAS, on March 9, 2020, the Governor of Rhode Island declared a state of emergency due to the dangers to health and life posed by COVID-19;

WHEREAS, on March 18, 2020, Lifespan's Incident Commander activated each of Lifespan's affiliated hospitals' Emergency Management Plan;

WHEREAS, the COVID-19 pandemic has created a national emergency and exceptional circumstance creating an urgent demand for health care providers to meet immediate patient needs beyond the capacity of Lifespan's affiliates' hospitals and their medical staffs;

WHEREAS, on April [], 2020, the Governor of Rhode Island ordered the establishment of several field hospitals within the state and through this order, the Governor directed Rhode Island Hospital ("RIH") to set up, staff and manage a field hospital operated under RIH's license r (the "RIH field hospital");

WHEREAS, the number of patients requiring hospitalization continues to rise in Rhode Island and at Lifespan's affiliated hospitals, increasing the need for healthcare providers and creating extraordinary circumstances which disrupt the normal credentialing processes by which providers are granted medical staff privileges at Lifespan's affiliates;

WHEREAS the current national emergency has required Lifespan's affiliated hospitals to grant Disaster Privileges under the hospitals' Medical Staff Bylaws to current affiliated hospital practitioners so that these providers may be shifted to work at any of the Lifespan affiliated hospital, including the RIH field hospital, to meet patient needs during the Covid-19 pandemic;

WHEREAS the current national emergency has required (or may require) Lifespan's affiliated hospitals to grant Disaster Privileges under the hospital's Medical Staff Bylaws to providers who were not members of any of Lifespan's affiliated hospitals' medical staffs prior to the activation of the hospitals' Emergency Management Plan;

WHEREAS, during the current national emergency it may be necessary to provide Disaster Privileges for some providers who do not meet all current eligibility requirements or who may not undergo all the documentation and assessment requirements and steps outlined in the Lifespan hospitals' Medical Staff Bylaws;

WHEREAS, during the current national emergency it may be necessary for a privileged practitioner to care for patients who have clinical needs beyond scope of the practitioner's current grant of privileges without meeting the appointment procedures for additional privileges set forth under the hospitals' Medical Staff Bylaws;

Now, therefore be it

RESOLVED that the Board has authorized that all privileges, including Disaster Privileges, granted to a practitioner at one Lifespan affiliated hospital may be exercised at any hospital within the Lifespan health system for the duration of the national emergency and the activation of each hospital's Emergency Management Plan in order to best allocate privileged personnel to meet patient needs in the current crisis.

RESOLVED that the Board authorizes any privileged practitioner to act during this period of national emergency and the activation of each hospital's Emergency Management Plan to provide care beyond his or her delineation of privileges as previously granted by the Board as long as it is care consistent with the practitioner's professional license and he or she has been directed to provide such care by a medical staff officer, department or service line chair, or hospital or Lifespan physician executive in order to serve urgent patient care needs.

RESOLVED that during this national emergency and the activation of each hospital's Emergency Management Plan the Board waives the reappointment date and expiration of the privileges of any practitioner who is currently appointed with privileges at any Lifespan affiliated hospital as of March 13, 2020 (the date the COVID-19 national emergency was declared). This extension of clinical privileges will last for the duration of the national emergency, after which the practitioner must be reappointed as soon as practicable as determined by the relevant Hospital CEO and medical staff President or Chief of Staff.

ADOPTED by the Board, April _____ 2020, effective March 18, 2020.

Exhibit 44F

CREDENTIALING PROCEDURES MANUAL

Rhode Island Hospital

March 2017

MEDICAL STAFF CREDENTIALING PROCEDURES MANUAL

The framework of the credentialing process is delineated in the Bylaws Manual Articles II, III and IX. The Credentialing Procedures Manual outlines some of the specific administrative details pertinent to the process.

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PART ONE: APPOINTMENT PROCEDURES

1.1 Pre-Application

Prior to releasing an application to any candidate, a pre-application form is sent to the candidate to determine eligibility to the Medical Staff or APP staff by the Medical Staff Office. The following information is solicited:

- a. office and residence address;
- b. staff category and clinical department requested;
- c. extent of anticipated practice at the Hospital;
- d. current/anticipated Medical Staff appointments and hospital affiliations; and
- e. copies of the following documents, as applicable:
 - i. current active, unrestricted license to practice
 - ii. federal Drug Enforcement Agency and Rhode Island controlled substances registration
 - iii. proof of professional liability insurance
 - iv. proof of successful completion of residency training program
 - v. proof of current board certification

Once the Medical Staff Office determines the candidate is eligible for appointment to the Medical Staff, a complete initial application packet is sent to the candidate.

1.2 Application Content

Every applicant must furnish complete information concerning at least the following: Professional school, and postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended, and names of practitioners responsible for monitoring the applicant's performance.

a. Professional Education and Training Qualifications

Medical Education

An "approved" allopathic medical school is one fully accredited throughout the period of the practitioner's attendance by the Liaison Committee on Medical Education or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

An "approved" osteopathic medical school is one fully accredited throughout the period of the practitioner's attendance by the American Osteopathic Association or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

An "approved" International Medical School is one that is listed in the *World Directory* as meeting eligibility requirements for its students and graduates to apply to ECFMG for ECFMG Certification and examination. The *World Directory* is available at www.wdoms.org. Graduates of these schools must also have a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or, have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Medical Residency Training Programs

An "approved" residency, or preliminary year of training is one fully accredited during the time of the practitioner's training by the Accreditation Council for Graduate Medical Education, or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body. Applicants who do not meet this requirement may be granted a waiver, as detailed in Section 3.8.2 in the Core Bylaws.

Podiatric Education

An "approved" podiatric medical school is one fully accredited throughout the period of the practitioner's attendance by the Council on Podiatric Medical Education or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body. Podiatric medical schools are governed by the American Association of Colleges of Podiatric Medicine (AACPM).

Podiatric Postgraduate Training

An "approved" podiatric residency is one fully accredited by the Council on Podiatric Medical Education during the time of the practitioner's training.

Dental Education

An "approved" school is one fully accredited throughout the period of the practitioner's attendance by the Commission on Dental Accreditation or by a predecessor or successor agency or by an equivalent professionally recognized accrediting body.

Dental Postgraduate Training

An "approved" postgraduate training program is one fully accredited during the time of the practitioner's training by the Commission on Dental Accreditation, or by a predecessor or successor agency or by an equivalent professionally recognized accrediting body.

Psychological Education and Training

A "recognized" graduate program in psychology is one fully accredited during the time of the practitioner's training by the American Psychological Association. A clinical internship in psychology is one accredited by the American Psychological Association. Accredited doctoral programs, internship and post-graduate residencies may be found on the APA Website:

http://apps.apa.org/accredsearch/?_ga=1.99974169.669107786.1464380096

- b. All past and all currently valid medical, dental and other professional licensures, permits or certifications, and Federal Drug Enforcement Administration (DEA) and other controlled substances registrations, with the date and number of each.
- c. Specialty or sub-specialty board certification, recertification, or eligibility status to sit for the examination. Each specialty will adhere to the eligibility rules set forth by the respective specialty board.
 - 1) Recognized Boards
 - a) Board Certification for allopathic and osteopathic physicians shall be in accordance with one of the boards recognized by the American Board of Medical Specialties.
 - b) Board Certification in dentistry shall be in accordance with any Dentistry specialties such as the American Board of Oral and Maxillofacial Surgery, the American Board of Periodontology, or the American Board the Pedodontists.
 - c) Board Certification in podiatric medicine shall be in accordance with one of the following specialty boards recognized by the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery.
 - 2) Board Eligibility - According to the Bylaws, upon appointment to the Medical Staff, a Medical Staff Member who is Board Eligible shall be required to register and take the next

board examination for which he/she is eligible. The duration of process to become Board Certified varies by Board and specialty. See Appendix A for descriptions of the Board Certification processes by Specialty.

- 3) Maintenance of Certification and Recertification – Requirements for maintaining Board Certification, as well as expiration dates for Certification varies by Board and by Specialty. See Appendix A for descriptions of MOC processes.
- d. Health status attestation including substance abuse issues, physical or mental health conditions, and requirements of Rhode Island statutes/regulations regarding healthcare workers.
- 1) Impairment Disclosure

When suspicion or knowledge of an ethical, medical, or behavioral problem is reported, a practitioner may be required to provide such information or to obtain such examination or tests as requested by the Medical Executive Committee. Such examinations shall be performed by a practitioner(s) designated by the Medical Executive Committee.

 - i. Physical or Behavioral Health Impairment: To be free of, or have under adequate control, any physical or behavioral health impairment that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to exercise requested clinical privileges or work cooperatively with others.
 - ii. Substance Abuse Disorder: To be free from abuse of any type of substance that affects cognitive or motor skills or interferes with the ability to exercise requested clinical privileges or work cooperatively with others. A practitioner may be required to submit to on-the-spot testing on the basis of physical manifestations on the job, suspicion based on recent performance, or as follow-up or concurrent monitoring of participation in a treatment program.
- e. Professional liability insurance coverage and information on malpractice claims history and experience (suits and settlements made, concluded and pending), including the names and addresses of present insurance carriers and insurance carrier(s) for the past ten years including Internship, Residency and Fellowship as applicable.
- f. Any pending or completed action involving denial, revocation, suspension, reduction, limitation, or probation of any of the following, and any non-renewal or relinquishment of or withdrawal of an application for any of the following to avoid investigation or possible disciplinary or adverse action.
- 1) License or certificate to practice any profession in any state or country
 - 2) Drug Enforcement Administration or other controlled substances registration
 - 3) Membership or fellowship in local, state or national professional organizations
 - 4) Faculty membership at any medical or other professional school
 - 5) Appointment or employment status, prerogatives or clinical privileges at any other hospital, clinic or health care institution or organization
 - 6) Professional liability insurance
 - 7) Medicare and/or Medicaid participation
- g. Hospital Affiliation and Work/Practice History: Applicants must submit every practice location since graduation from professional/Medical School. Documentation must include location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association in month/year format; names and locations of all other hospitals, clinics or health care institutions or organizations where the applicant provides or provided clinical

services with the inclusive dates of each affiliation in month/year format, status held, and general scope of clinical privileges.

- h. Department/Division assignment, Medical Staff category, and specific clinical privileges requested.
- j. Any current criminal charges pending against the applicant and any past charges including their resolution.
- k. Required peer references.
- l. Evidence of the applicant's agreement with the confidentiality, immunity, and release provisions of the Medical Staff Bylaws and related manuals.
- m. Signed Medical Staff Code of Conduct Attestation Sheet
- n. Other elements required by Hospital or health system policy such as confidentiality statements, HIPAA compliance attestation, and Information System Security items.
 - 1) Criminal Background Check Release Form
 - 2) HIPAA Security Policy (IS 209)
 - 3) Patient Safety Policy
 - 4) HIPAA Privacy Policy Attestation
 - 5) Medicare/CHAMPUS Physician Acknowledgment
 - 6) Lifespan Confidentiality Statement Attestation
 - 7) Corporate Compliance Program Attestation
 - 8) Policy Regarding Interaction with Industry Representatives from the Pharmaceutical, Medical Device and Medical Supply Industries - Attestation
 - 9) EMTALA Policy
- o. Identification verification as referenced by The Joint Commission Standards, MS06.01.03 EP5
- p. Immunization records as mandated by the Rhode Island Department of Health for Healthcare workers.
- q. Documentation of physician coverage for applicants requesting admitting privileges.
- r. Explanation and details on any gaps in excess of thirty days within career progression since graduation from professional/Medical School.
- s. Detailed descriptions of any post-graduate training specialty and/or program changes within the same institution or not.

1.3 Special Considerations – Staff Category

1.3-1 Courtesy Staff

- a) Obligations. Bylaws Section 2.3.4 stipulates that Courtesy Staff members may be required to fulfill one or more of the Active Staff obligations under extraordinary circumstances. If a Department Chair needs to invoke any of these obligations for a Courtesy Staff member(s), he/she shall forward the plan with extenuating circumstances and time frame to the Medical Executive Committee for approval.

In the event that immediate action is necessary, the Officers of the Medical Staff shall review and act upon the Department Chair's plan until the next meeting of the full Medical Executive Committee.

- b) Volume. A Courtesy Staff member will be requested to change his/her staff category to Active and meet all obligations of the Active Staff category if he/she admits or provides services on the average to more than 15 patients in any 12-month period.

The following exceptions to these volume considerations apply (in addition to the coverage stipulation noted in the Bylaws):

1. When it can be demonstrated that the excess volume occurred because of a unique set of circumstances that are unlikely to continue or occur again.
2. For Closed-Staff Service Departments
 - Anesthesiologists
 - Emergency Medicine Physicians
 - Pathologists
 - Radiation Oncologists
 - Radiologists
3. For surgical assistants since they are not primarily responsible for the patient.
4. For circumstances that are related to coverage purposes only.

1.3-2 Doctoral Staff

Candidates to the Doctoral staff need to be credentialed and privileged if the provider engages in patient interaction that includes treatment protocols and/or uses information for clinical conclusions and care of patients. MSS is advised to seek guidance from the appropriate CMO(s) with questions related to whether a particular candidate should be privileged or not.

1.3-3 Research Scientists

Research Scientists should be credentialed if the research being conducted includes any patient interaction or if the research project comes under the auspices of the IRB (human studies). MSS is advised to seek guidance from the CMOs and Research Administration with questions related to credentialing.

1.4 Application Fees

The Medical Executive Committee, with input and endorsement by Hospital Administration will determine application fees for appointment and reappointment. The fee schedule will be maintained in the Medical Staff Services Office. The application fee must accompany the submitted application and is non-refundable. The application will not be deemed complete until the application fee is received.

1.5 References

The application must include the names of at least three (3) professional references. For applicants in the Associate and Research Scientist categories, one (1) professional reference is required. The named individuals must have equivalent licensure and have had extensive experience in observing and working with the applicant professionally within the past year and can attest to current clinical competency, ethical character, and ability to work cooperatively with others, and who will provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. In most cases, members of the current/potential practice group, training colleagues, the Chief of the RIH or TMH Department to which applicant is applying to or family members and significant others **may NOT** serve as references. At least one reference must practice in the applicant's clinical specialty.

The references will be asked to provide written comments on the following specific areas:

- Medical/Clinical Knowledge

- Technical and Clinical Skills
- Clinical Judgment
- Interpersonal Skills
- Communication Skills
- Professionalism

1.6 Effect of Application

The applicant must sign the application and in so doing:

- a) Attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or termination from the Staff without recourse to the procedural rights;
- b) Agrees to notify the Medical Staff Services Office of any change made or proposed in the status of his/her professional license or permit to practice, Federal DEA or other controlled substances registration, malpractice insurance coverage, membership, employment status or clinical privileges at other institutions/facilities/organizations, and on the status of current or initiation of new malpractice claims;
- c) Agrees to abide by the terms and elements of Bylaws Manual Article III.

1.7 Processing the Application

1.7-1 Applicant's Burden

- a) The applicant has the burden to produce adequate information for a proper evaluation of his/her experience, training, current competence, utilization practice patterns, Continuing Medical Education (CME), and peer references. It is the applicant's responsibility to resolve any doubts about these or any of the qualifications required for Medical Staff appointment or the requested Medical Staff category, Department or Section assignment, or clinical privileges, and to satisfy reasonable requests for information or clarification made by appropriate Staff or Board authorities.
- b) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 90 days after the individual has been notified of the additional information required may be deemed to be withdrawn. If an applicant is responsive to requests from the Medical Staff Office, an application may remain open for up to one (1) year. The individual seeking appointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- c) Personal interviews may be requested by a Department or the Credentials Committee and conducted as appropriate.

1.7-2 Verification of Information

The completed application is submitted to the Medical Staff Services Office and the applicable Department Chairs and Sections Chiefs are notified of its receipt.

The Medical Staff Services Office personnel will conduct primary source verification of the following items:

- a) Any professional license or certification in the state of Rhode Island and any other states where licensure has ever been held
- b) Education including, professional, ECFMG (if applicable)
- c) Training including internship, residency, fellowship (both clinical and research)
- d) Board Certification
- e) Liability coverage and malpractice claims for past 10 years. All found claims, regardless of outcome, will be reviewed by Lifespan's Risk Management Department.
- f) Prior affiliations, work history since graduation of professional/Medical School
- g) Physician/group coverage plan for applicants requesting admitting privileges
- h) Nationwide Criminal Background Screening

Direct submission of written peer references qualifies as primary source verification that can be used when determining current clinical competence. Additional evaluations from external Department Chiefs will be solicited as applicable.

In addition, Medical Staff Services Office personnel will query the National Practitioner Data Bank (NPDB) and OIG and SAM (Excluded Parties List for Medicare/Medicaid).

Applicants will be promptly notified by telephone, mail, or electronic mail of any inconsistencies that arise during the application verification process. If a response has not been received by the tenth day following such notification, a second notification shall be given. This notice will indicate the nature of the additional information the applicant is to provide within a specified time frame. Failure without good cause, to respond in a satisfactory manner by that date may be deemed a voluntary withdrawal of the application.

The list of clinical privileges requested will be sent to all clinical affiliations since graduation to obtain specific information regarding the applicant's experience and competence in exercising each of the privileges requested. Ideally, such verification should address at least the following two specific aspects of current competence:

- (a) For applicants requesting privileges that are surgical or invasive in nature, the number and types of surgical procedures performed as the surgeon of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes. In the case of applicants in nonsurgical fields, the number and types of privileges held to manage the medical conditions by the applicant as the responsible practitioner will be requested. This information may be requested directly from the applicant if not provided by prior facilities.
- (b) The applicant's clinical judgment and technical skills.

Once verification is accomplished, the Medical Staff Services Office will initiate the application review process by informing those involved that the application and all supporting materials are available for review.

1.7-3 Content of Assessments and Bases for Recommendations and Actions

The assessment of each individual or group required to review an application and act on it, must include recommendations for approval, denial, and/or any special limitations on the Medical Staff appointment,

staff category, Department and/or Section affiliation, and requested clinical privileges. All documentation and information received by any individual or group during the evaluation process must be included with the application as part of the individual's central credentials file and must be transmitted with the reports and recommendations, as appropriate or requested. The reasons for each recommendation or action to deny, restrict or otherwise limit credentials must be stated, with reference to the completed application and all documentation considered. The report recommendations must be based on the individual's professional qualifications, the individual's ability to deliver quality patient care in an efficient manner, the demonstrated Hospital and community need for the services, the Hospital's capabilities of supporting the requested privileges, and the individual's ability to have qualified coverage of the care requested.

PART TWO: INDIVIDUALIZED PROFESSIONAL PRACTICE EVALUATION PROCESS

2.1 FPPE

All initial applicants in all staff categories with privileges will undergo a Focused Professional Practice Evaluation (FPPE). Applicants are proctored utilizing one or more of the following as part of the FPPE process:

- Concurrent proctoring: real-time observation of a procedure (*Applicable to: performance of procedures. Minimum Standard: Observation of initial three (3) operative/procedural cases*)
- Retrospective proctoring: review of a case after care has been completed, which may include interviews with personnel involved in the care of the patient.

During the review process of initial applications, the Department Chair, or designee will identify a proctor name and proctoring type, as described above, on the recommendation page in the credentialing packet. Upon Board of Trustee approval to the Medical Staff, the Medical Staff Office communicates directly with the newly appointed member outlining the FPPE policy and process, and provides the appropriate proctoring document(s). The communication states the BOT approval date and that the first cases at the facility should be proctored. It is the applicant's responsibility to coordinate with the proctor to have the proctoring forms completed. The completed forms are then returned to the Medical Staff Office. Once completed proctoring forms are returned, a FPPE review packet is prepared for the department chief which include the completed proctoring forms. After Department Chair approval, successful completion of the FPPE is documented in the Medical Staff credentialing software, and the member is notified when the FPPE period is concluded. Outcome summaries of FPPE review reports are also submitted to the Credentials Committee.

Refer also to the FPPE policy Admin 191 of the Rhode Island Hospital Administrative Policy Manual and TJC standard MS08.01.01.

There are occasions during the initial applicant review process that a specific enhanced FPPE program is requested, by either Department or the Credentials Committee. In these situations, the Medical Staff Office, documents the specifics of the FPPE plan, notifies the proctor and the department chief of the details of the FPPE as well as the applicant. The Medical Staff Office then tracks the completion of the specific program and provides reports to the Credentials Committee as requested.

2.2 OPPE

All applicants with privileges, including initial applicants, participate in the Ongoing Professional Practice Evaluation (OPPE) process. Each department, in collaboration with the OpX department, establishes criteria on which to base the OPPE analysis. Data is summarized and reviewed by the Department Chair, or an approved delegated medical staff leader, on a semi-annual basis.

Refer also to the OPPE policy Admin 190 of the Rhode Island Hospital Administrative Policy Manual and TJC standard MS08.01.03.

PART THREE: REAPPOINTMENT PROCEDURES

3.1 Information Collection and Verification

Reappointment applications are distributed 6 months in advance of the appointment cycle expiration date. Applicants are requested to return the reappointment application and supporting documentation approximately 5 months ahead of the cycle end date.

3.1-1 Timeliness of applicant response

Rarely, an applicant will not return an application and supporting documentation in a timely manner, despite repeated notifications and reminders by MSS, and a lapse in privileges occurs (not in relation to an LOA). If the duration of the privileges is 1 day to 6 months after the deadline, the provider will need to complete the reappointment application and pay the initial application fee of \$275.

3.1-2 Types of Information Obtained

The Medical Staff Services Office collects all relevant information regarding the individual's professional and collegial activities, performance and conduct in this Hospital. Such information, which together with the information obtained from the applicant and other external sources shall form the basis for recommendations and action. These shall include, without limitation:

- (a) Clinical performance and patterns of care as demonstrated in the findings of direct observation, quality assessment and improvement, risk management and utilization management activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (where available), provided that other practitioners shall not be identified. This information will include data obtained through the OPPE process over the last 4 semi-annual reporting periods. (Refer also to the OPPE policy Admin 190 of the Rhode Island Hospital Administrative Policy Manual);
- (b) Participation in relevant continuing education activities;
 - (i) Physician applicants for reappointment must submit documentation of at least 40 hours of American Medical Association (AMA) Category I continuing medical education (CME) credits earned during the preceding two years consistent with Rhode Island medical licensure regulations.
 - (ii) All other practitioners will submit documentation of sufficient CME/CEU to meet the requirements promulgated by their corresponding state licensure board averaged over the two-year appointment interval.
- (c) All applicants will have clinical judgment and technical skills assessed. The level/amount of clinical activity (patient care contacts) at the Hospital will be obtained. These data will be obtained by MSS from OpX or from the provider. MSS will ensure appropriate documentation for all criteria based or volume based privileges.
 - (i) Data for applicants in fields performing surgical or other invasive procedures will include the number and types of procedures performed as the surgeon/proceduralist of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes and patient care management and consultations performed.

- (ii) Data for applicants for reappointment in nonsurgical fields will include the number and types of medical conditions managed/consulted and the procedures performed by the applicant as the responsible practitioner.
- (d) Sanctions imposed or pending
- (e) Attendance at required Medical Staff, Department, Division, and Committee meetings, as specified by Departmental policy;
- (f) Participation as a Medical Staff official, committee member/Chair and proctor, and in on-call coverage roster;
- (g) Timely and accurate completion and preparation of medical records;
- (h) Cooperativeness in working with other practitioners and Hospital personnel;
- (i) General attitude toward patients and the Hospital;
- (j) Peer Reference(s).
- (k) Compliance with all applicable bylaws, policies, rules, and procedures of the Hospital and Medical Staff;
- (l) Any other pertinent information that may be relevant to the Medical Staff member's status and privileges at this Hospital, including the Medical Staff member's activities at other hospitals and medical practice outside the Hospital.

3.1-3 Volume Considerations

Applicants with limited clinical activity at the Hospital are considered to be low volume providers. Consideration of these providers is outlined in Bylaws 3.6.1c.

Courtesy Staff volume exceptions are noted in Section 1.2-1.

3.1-4 Verification of Information

The Medical Staff Services Office personnel will conduct primary source verification of the following items:

- (a) Any professional license
- (b) Board Certification/recertification
- (c) Additional training cited in the reappointment application
- (d) Liability coverage and claims history (with review and signoff by Risk Management if needed)
- (e) Other hospital affiliations

In addition, the National Practitioner Databank will be queried.

3.1-5 Aging Practitioners

Policy and Process to be determined by Hospital Administration and MEC.

3.2 Content of Report and Bases for Recommendations and Action

The report of each individual or group required to act on an application must include recommendations for approval, denial, and/or any special limitations on the Medical Staff appointment, staff category, Department and/or Section affiliation, and requested clinical privileges. All documentation and information received by any individual or group during the evaluation process must be included with the application as part of the individual's central credentials file and must be transmitted with the reports and recommendations, as appropriate or requested. The reasons for each recommendation or action to deny, restrict or otherwise limit credentials must be stated, with reference to the completed application and all documentation considered. The report recommendations must be based on the individual's professional qualifications, the individual's ability to deliver quality patient care in an efficient manner, the demonstrated Hospital and community need for the services, the Hospital's capabilities of supporting the requested privileges, and the individual's ability to have qualified coverage of the care requested.

PART FOUR: DELINEATING CLINICAL PRIVILEGES

4.1 Department Responsibility to Define Approach to Delineating Privileges

Each Department must define, in writing, the conditions, operative, invasive and other special procedures that fall within its clinical area, including levels of severity or complexity, age groupings as appropriate, and the requisite training, experience or other qualifications required. These definitions must be incorporated in the processes used for requesting and granting privileges and must be approved by the Credentials Committee, the Medical Executive Committee, and the Board. The scope and processes must be periodically reviewed and revised as necessary to reflect new procedures, instrumentation, treatment modalities and similar advances or changes.

When processes are revised, by additions or deletions or the adoption of new privilege forms, all Medical Staff members holding privileges in the Department must, complete the new forms, request and be processed for privileges added, or comply with the fact that a privilege was deleted.

4.2 Contractual or Employment Relationships

4.2-1 Medical Staff Appointment

A practitioner who is or who will be providing specified professional services pursuant to a contract/employment with the Hospital must meet the same qualifications for appointment to the Medical Staff, must be evaluated for Medical Staff appointment, reappointment and clinical privileges in the same manner, and must fulfill all of the obligations of the medical staff category as any other applicant for Medical Staff appointment.

4.2-2 Effect of Medical Staff Appointment Termination or Clinical Privileges Restriction

Practice at the Hospital is contingent upon continued Medical Staff membership and is also constrained by the extent of clinical privileges granted.

A practitioner's right to use Hospital facilities is therefore automatically terminated when Medical Staff membership expires or is terminated. Similarly, the extent of practice at the Hospital is automatically limited to the extent that clinical privileges are restricted or revoked.

The effect of an adverse change in clinical privileges on continuation of the contract/employment arrangement is governed solely by the terms of the contract/employment arrangement.

4.2-3 Effect of Contract Expiration or Termination

The effect of expiration or other termination of a practitioner's contract/employment agreement upon the practitioner's Medical Staff membership and clinical privileges will be governed solely by the terms of the contract/employment agreement with the Hospital, if it addresses the issue.

If the contract/employment arrangement is silent on the matter, then expiration or other termination of the contract alone will not affect the practitioner's medical staff membership or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which exclusive contractual arrangements have been made.

4.3 Medical Administrative Positions

4.3-1 Medical Staff Appointment

Practitioner(s) engaged by the Hospital in a medical administrative capacity, such as Division Directors, whose professional activities may also include clinical responsibilities such as direct patient care or teaching and/or supervision of patient care activities of other practitioners may need achieve and maintain Medical Staff appointment and clinical privileges appropriate to the clinical responsibilities and discharge Medical Staff obligations appropriate to the granted Medical Staff category and in the same manner applicable to all other Medical Staff members. Refer also Article IV of the Medical Staff Bylaws.

4.3-2 Effect of Medical Staff Appointment Termination or Clinical Privileges Restriction

Adverse revocation of Medical Staff appointment and all clinical privileges precludes continuing in the medical administrative capacity as applicable.

The adverse revocation of select clinical privileges will initiate review of continued medical administrative service.

4.3-3 Effect of Contract Expiration or Termination

Removal or resignation from the medical administrative position alone does not affect the individual's Medical Staff membership or clinical privileges.

PART FIVE: MODIFYING CLINICAL PRACTICE

5.1 Relinquishment of Clinical Privileges

A Medical Staff member or APP who chooses to no longer exercise or to voluntarily restrict or limit the exercise of specific privileges which have previously been granted shall send written notice to the appropriate Department Chair indicating the same and identifying the particular privileges involved and applicable restrictions or limitations. This request for a change in privileges shall be routed for review as outlined in Section 3.3.7 – 3.3.10 of the Bylaws. Documentation of the change of privileges is included in the member's credentials file.

5.2 Increase in Clinical Privileges

A Medical Staff member who wishes to request additional specific privileges which have not previously been granted shall send written notice to the appropriate Department Chair or Medical Staff Office indicating the same and identifying the particular privilege(s) involved. MSS will obtain the following information from the applicant:

1. Letter of Intent (reason for the request)
2. Updated Privilege/Patient Care Services form (if applicable)
3. Supporting Clinical Activity/Patient encounters in support of increase of privileges
4. Updated malpractice insurance certificate (if applicable)
5. Group Coverage List and Verification (if applicable)

A completed change of status packet will be routed for review as outlined in Section 3.3.7 – 3.3.10 of the Bylaws. Documentation of the change of privileges will be included in the member's credentials file.

Once the change of privileges has been approved, the applicant will be notified to complete the FPPE process as outlined in Part II above; and all data systems will be updated as appropriate.

5.3 Modification of Practice Status

A Medical Staff member who plans to make a significant change in his/her practice situation shall send advanced written notice to the appropriate Department Chair or Medical Staff Services indicating the particulars of the change. Examples include leave of absence, resignation, retirement, changes in practice location, changes in practice association, and changes in employment relationship with the hospital. When MSS receives notice of changes in practice status from other sources, changes will be verified with the practitioner prior to documenting the change in status in MSS credentialing database(s).

Depending on the nature of the change, MSS will update appropriate data systems per policy and practice. Resignations, including the reason for the resignation, are documented in the Credentials Committee Report for review by the MEC and BOT.

5.3-1 Leaves of Absence

Circumstances that require notification to MSS include long term sabbatical type leaves and health related leaves that would potentially impact one's ability to provide care in the long term. Short term health related situations, e.g. pregnancy, recovery from a non-debilitating injury, etc, do not require that a formal leave of absence be initiated. Should MSS have questions regarding whether a practitioner needs to be placed on a formal LOA per the bylaws, MSS will contact the appropriate Department Chief and/or CMO for guidance and resolution.

An LOA cannot alter the appointment cycle of the practitioner. MSS will communicate to Chiefs and Practitioners on a LOA that the reappointment process takes 60-90 days to ensure providers understand the timeframe involved in the reappointment process to assist in avoiding lapses in privileges. MSS will also notify the Chief and practitioner that a re-appointment can be processed early to prevent a lapse in privileges.

PART SIX: SPECIAL PRIVILEGING PROCEDURES**6.1 Procedure for Granting Temporary Privileges**

The process for granting temporary privileges is described in the Core Bylaws. MSS facilitates communication between Department Chief, CMO, Medical Staff President, Credentials Committee Chair and Hospital President to document the approval process, and notifies the applicant of the final outcome in writing.

6.2 Procedure for Granting Disaster Privileges**6.2-1 Conditions**

In addition to the Bylaws Manual provisions regarding Disaster Privileges, volunteer practitioners will be teamed with Medical Staff members to permit direct observation of care rendered and provide monitoring opportunities and procedural guidance. As circumstances permit or dictate, clinical record reviews will be undertaken to ensure quality of care rendered.

All grants of disaster privileges shall reflect the individual's training and specialty.

PART SEVEN: ADVANCED PRACTICE PROFESSIONALS

7.1 Definition

As defined in Bylaws Article IX, Advanced Practice Professionals (APPs) shall include designated independent and non-independent health care professionals who are qualified by formal training, licensure, and current competence in a health care discipline which the Board of Trustees has approved for practice within the Hospital's scope of services. There are 2 Staff Categories: APP, which is for those practitioners who need privileges at a Lifespan owned and operated facility; and 2) Associate APP, which is for those who do not want privileges to provide care at a Lifespan owned and operated facility, but want/need affiliation with a Lifespan hospital.

7.2 Eligible Practitioners

The specific disciplines include:

- Acupuncturist
- Certified Registered Nurse Anesthetist
- Nurse Practitioner
- Optometrist
- Physician Assistant
- Psychiatric Clinical Nurse Specialist
- Radiology Assistant

7.3 Qualifications

A statement of qualifications for each category of APP shall be developed for review by the Credentials Committee, subject to approval by the Board. Each such statement must:

- (a) Be developed with input, from the Chief of the applicable Department(s) or Division(s), and other key stakeholders; and
- (b) Require that the individual APP hold a current license, certificate or such other credential, as may be required by Rhode Island law to exercise the privileges or provide the services being requested; and
- (c) Be delineated on each individual privilege form.

7.4 Prerogatives and Obligations

Prerogatives are listed in the Bylaws.

Each Advanced Practice Professional is obligated to the following:

- (a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate Hospital facilities.
- (b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services and, when necessary and as appropriate to the circumstances of the case, either arrange or alert the principal attending physician of the need for a suitable alternative for such care and supervision.

- (c) Participate when requested in quality review and risk management program activities and in such other functions as may be required from time to time.
- (d) Attend clinical and educational meetings of the Medical Staff and of the Department or Section and any other clinical units with which affiliated.
- (e) May be appointed to serve on Medical Staff Committees and may also be invited to specified Medical Staff meetings, but only at the pleasure of the invitation of the Medical Staff President.
- (f) Abide by the Medical Staff Bylaws and related manuals, the Hospital Bylaws, and all other standards, policies and rules of the Medical Staff and Hospital.
- (g) Prepare and complete in a timely fashion as required in the Medical Staff Rules and Regulations those portions of patients' medical records documenting services provided and any other required records.
- (h) Refrain from any conduct or acts that are or could be reasonably interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

7.5 Scope of Privileges and Service Description

Notwithstanding the apparent scope of practice permitted to any group of Advanced Practice Professional under Rhode Island law or licensure, the scope of privileges and guidelines described above may place limitations on the scope of practice authorized in the Hospital as deemed necessary for the efficient and effective operation of the Hospital or any of its departments or services; for management of personnel, services and equipment; for quality or efficient patient care; or as otherwise deemed by the Board to be in the best interests of patient care in the Hospital.

The scope of practice or granted patient care services available to any group of Advanced Practice Professional shall be developed with input from the appropriate Department Chairs and Section Chiefs, as applicable, and representatives of management. The scope and description of patient care services will be reviewed by the Credentials Committee and recommended for approval to the MEC and BOT. The scope is subject to the approval of the Board.

7.6 Subcategories of Advanced Practice Professionals

As noted in Section 7.1, the Advanced Practice Professionals designation includes designated independent and non-independent health care professionals.

7.6-1 Independent Advanced Practice Professionals

An Independent Advanced Practice Professional is an individual who fulfills the criteria in Bylaws Article IX but is permitted by the Hospital to provide services independently in the Hospital, i.e., without the direction or immediate supervision of a physician, and is not required to have documentation countersigned.

Current policy permits the following types of Advanced Practice Professionals to provide independent services in the Hospital: **Not applicable**

7.6-2 Non-independent Advanced Practice Professionals

A Non-independent Advanced Practice Professional is an individual who is qualified by licensure, certification, or academic and/or clinical training and current competence to function in a medical support role to, and under the direction and supervision of, a practitioner and who is in a health care discipline which the Board has approved to practice in the Hospital.

Current policy permits the following types of Advanced Practice Professionals to provide non-independent services in the Hospital:

- Acupuncturist
- Certified Registered Nurse Anesthetist
- Nurse Practitioner
- Optometrist
- Physician Assistant
- Psychiatric Clinical Nurse Specialist
- Radiology Assistant

Continued affiliation as a Non-independent Advanced Practice Professional is contingent upon maintenance of the employment or contractual relationship with the supervising physician. Termination of this relationship will result in an automatic termination of clinical hospital affiliation. Termination of clinical hospital affiliation for this reason does not entitle the APP to procedural rights to due process.

7.7 Terms and Conditions of Affiliation

Each Advanced Practice Professional shall be assigned to a Department(s) and Division(s), if applicable, appropriate to his/her professional training and is subject to an initial Focused Professional Practice Evaluation utilizing metrics defined by the Department/Division.

An Advanced Practice Professional's provision of specified services within any Department or Division is subject to the rules and regulations of that Department and Section and to the authority of the Department or Division Chief, as applicable. The quality and efficiency of the care provided by APPs within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or Hospital quality review, risk management and utilization management mechanisms.

7.8 Appointment and Re-appointment Procedures

APPs will be subject to the same procedures as defined in Parts 1- 6 of this manual.

PART EIGHT: EXPIRING CREDENTIALS

8.1 Process

At the beginning of each month, Medical Staff Services identifies from the credentialing data base, all providers who have an expiring credential at the end of that month. Notification is sent to the provider via email (and fax) stating:

“Evidence of current credentialing documentation is a requirement for privileges and/or membership at all Lifespan affiliated hospitals. This letter is to inform you that required documentation will be expiring on the date listed. Medical Staff Services must receive a copy of this documentation prior to the expiration date to avoid any disruption to clinical privileges at a Lifespan affiliated hospital.”

Follow-up occurs every two weeks until credential is received. If the credential is not received that information is brought to the attention of the MSS Managers and clinical leadership if necessary, for further action.

8.2 Types of Expiring Credentials by Applicable Staff Category

Expiring Credentials	Staffing Categories Expiring Credentials are Applicable to
Malpractice Insurance	Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Advanced Practice Professionals
Federal DEA Registration	Active, Senior Active, Courtesy, Consulting, Advanced Practice Professionals (NP & PA only)
State Licensure and Substance Control	Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Advanced Practice Professionals
Advanced Practice Certifications	Advanced Practice Professionals
Privileging Criteria Certifications – ACLS, PALS, Neonatal Certification	Active, Senior Active, Courtesy, Consulting, Advanced Practice Professionals who hold privileges requiring certification
Tuberculosis Testing (RIH/TMH)	Active, Senior Active, Courtesy, Consulting, Doctoral, Advanced Practice Professionals

PART NINE: ADOPTION

9.1 This Credentialing Procedures Manual was reviewed and adopted by the RIH Credentials Committee on [date]

Appendix 1 - Board Certification and MOC Requirements by Specialty (See Excel Document)

ARTICLE III

MEDICAL STAFF APPOINTMENT

3.1 **Appointment not Automatic** – Practitioners are not automatically entitled to the granting of staff appointment or particular clinical privileges merely because of licensure to practice in this or any other state; certification by any clinical or specialty board; membership of a medical, dental or other professional school faculty; or present or past Medical Staff membership or privileges at another health care facility, including another Lifespan affiliate.

3.2 **Initial Appointment: Qualifications**

3.2.1 **Education**

- a. In order to be initially appointed to the Active, Courtesy, Consulting, or Associate Staff, an individual shall:
 - i. be a graduate of an approved medical (allopathic or osteopathic), dental or podiatric school reviewed and recommended by the Medical Executive Committee and approved by the Board; or
 - ii. be certified by the Educational Council for Foreign Medical Graduates; or
 - iii. have a Fifth Pathway certification and have successfully completed the Foreign Medical Graduate Examination in Medical Sciences; and
 - iv. have satisfactorily completed an approved residency reviewed and recommended by the Medical Executive Committee and approved by the Board.
- b. In order to be initially appointed to the Doctoral Staff, an individual shall be a graduate of a recognized graduate program in psychology and shall have satisfactorily completed a clinical internship in psychology reviewed and recommended by the Medical Executive Committee and approved by the Board.
- c. In order to be initially appointed as a Research Scientist, an individual shall hold an advanced doctoral degree from a recognized graduate program in a field of research reviewed and recommended by the Medical Executive Committee and approved by the Board.

3.2.2 **Licensure**

- a. In order to be initially appointed to the Active, Courtesy, Consulting, Doctoral, or Associate Staff, an individual shall have an active, unrestricted license to practice medicine, dentistry, podiatry or psychology in the State of Rhode Island.
- b. In order to be initially appointed to the Active, Courtesy, Doctoral, Consulting, or Associate Staff under an external resource sharing agreement, or equivalent, with a military or other federal service organization, an individual shall have an

active, unrestricted license to practice medicine, dentistry, podiatry, or psychology in any state.

- 3.2.3 **Board Certification and Eligibility** – In order to be initially appointed to the Active, Courtesy, or Consulting Staff, an individual shall be Board Eligible or Board Certified in accordance with Section 3.8.
- 3.2.4 **Clinical Competence** – In order to be initially appointed to the Active, Courtesy, Consulting, or Doctoral Staff, an individual must demonstrate clinical competence and physical and mental status sufficient to demonstrate that he/she is able to provide quality care to patients.
- 3.2.5 **Duty of Cooperation** – An applicant for initial appointment to the Medical Staff must attest to his/her intent to comply with all recognized standards of medical and professional ethics and to abide by the Medical Staff code of conduct. An applicant must have the ability to function in a cooperative and reasonable manner with others in the Hospital environment. This ability is essential to providing quality medical care to patients in a safe and effective manner and shall be considered as part of the application process.
- 3.2.6 **Insurance** – In order to be initially appointed to all categories of the Medical Staff, except Honorary Staff and Research Scientists, an individual shall be insured for professional liability by a reputable insurer, as determined by the Board, in such amounts as the Board from time to time shall establish.
- 3.2.7 **Required Disclosures** – In addition to information specifically requested on the application, an applicant for initial appointment to the Medical Staff must disclose any fact that could reasonably be expected to have a negative impact on the applicant's candidacy. This shall include, but not be limited to, any information about whether the applicant's enrollment, certification, membership status, clinical privileges, or license to practice any profession have ever been voluntarily or involuntarily revoked, denied, relinquished, suspended, limited, reduced or not renewed by any healthcare or other entities, including but not limited to:
 - a. a specialty board;
 - b. state or federal jurisdiction;
 - c. Medicare, Medicaid or state or federal Drug Enforcement Agency;
 - d. healthcare entity;
 - e. educational institution or program; or
 - f. local, state or national professional organizations.

In addition, an applicant must disclose the following information:

 - g. evidence of current professional liability insurance coverage and the amounts thereof;

ARTICLE III

MEDICAL STAFF APPOINTMENT

3.1 **Appointment not Automatic** – Practitioners are not automatically entitled to the granting of staff appointment or particular clinical privileges merely because of licensure to practice in this or any other state; certification by any clinical or specialty board; membership of a medical, dental or other professional school faculty; or present or past Medical Staff membership or privileges at another health care facility, including another Lifespan affiliate.

3.2 **Initial Appointment: Qualifications**

3.2.1 **Education**

- a. In order to be initially appointed to the Active, Courtesy, Consulting, or Associate Staff, an individual shall:
 - i. be a graduate of an approved medical (allopathic or osteopathic), dental or podiatric school reviewed and recommended by the Medical Executive Committee and approved by the Board; or
 - ii. be certified by the Educational Council for Foreign Medical Graduates; or
 - iii. have a Fifth Pathway certification and have successfully completed the Foreign Medical Graduate Examination in Medical Sciences; and
 - iv. have satisfactorily completed an approved residency reviewed and recommended by the Medical Executive Committee and approved by the Board.
- b. In order to be initially appointed to the Doctoral Staff, an individual shall be a graduate of a recognized graduate program in psychology and shall have satisfactorily completed a clinical internship in psychology reviewed and recommended by the Medical Executive Committee and approved by the Board.
- c. In order to be initially appointed as a Research Scientist, an individual shall hold an advanced doctoral degree from a recognized graduate program in a field of research reviewed and recommended by the Medical Executive Committee and approved by the Board.

3.2.2 **Licensure**

- a. In order to be initially appointed to the Active, Courtesy, Consulting, Doctoral, or Associate Staff, an individual shall have an active, unrestricted license to practice medicine, dentistry, podiatry or psychology in the State of Rhode Island.
- b. In order to be initially appointed to the Active, Courtesy, Doctoral, Consulting, or Associate Staff under an external resource sharing agreement, or equivalent, with a military or other federal service organization, an individual shall have an

active, unrestricted license to practice medicine, dentistry, podiatry, or psychology in any state.

- 3.2.3 **Board Certification and Eligibility** – In order to be initially appointed to the Active, Courtesy, or Consulting Staff, an individual shall be Board Eligible or Board Certified in accordance with Section 3.8.
- 3.2.4 **Clinical Competence** – In order to be initially appointed to the Active, Courtesy, Consulting, or Doctoral Staff, an individual must demonstrate clinical competence and physical and mental status sufficient to demonstrate that he/she is able to provide quality care to patients.
- 3.2.5 **Duty of Cooperation** – An applicant for initial appointment to the Medical Staff must attest to his/her intent to comply with all recognized standards of medical and professional ethics and to abide by the Medical Staff code of conduct. An applicant must have the ability to function in a cooperative and reasonable manner with others in the Hospital environment. This ability is essential to providing quality medical care to patients in a safe and effective manner and shall be considered as part of the application process.
- 3.2.6 **Insurance** – In order to be initially appointed to all categories of the Medical Staff, except Honorary Staff and Research Scientists, an individual shall be insured for professional liability by a reputable insurer, as determined by the Board, in such amounts as the Board from time to time shall establish.
- 3.2.7 **Required Disclosures** – In addition to information specifically requested on the application, an applicant for initial appointment to the Medical Staff must disclose any fact that could reasonably be expected to have a negative impact on the applicant's candidacy. This shall include, but not be limited to, any information about whether the applicant's enrollment, certification, membership status, clinical privileges, or license to practice any profession have ever been voluntarily or involuntarily revoked, denied, relinquished, suspended, limited, reduced or not renewed by any healthcare or other entities, including but not limited to:
 - a. a specialty board;
 - b. state or federal jurisdiction;
 - c. Medicare, Medicaid or state or federal Drug Enforcement Agency;
 - d. healthcare entity;
 - e. educational institution or program; or
 - f. local, state or national professional organizations.

In addition, an applicant must disclose the following information:

 - g. evidence of current professional liability insurance coverage and the amounts thereof;

- i. Time Period for Additional Information – In the event the Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Office of Medical Staff Services shall provide the applicant with Special Notice. The notice must state with specificity the additional information being sought and that the applicant has ten (10) days in which to respond. Failure to respond in a satisfactory manner within this timeframe, without good cause as determined by the SVPMA/CMO, may be deemed a voluntary withdrawal of the application.
- ii. Favorable Assessment – A favorable assessment for applicant appointment by the Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) shall include, where appropriate, a recommendation for the clinical privileges to be granted. Pursuant to individualized professional practice evaluation requirements, the assessment shall delineate special circumstances of review, identify the proposed proctor, if required, and whether the evaluation will be concurrent or retrospective.
- iii. Unfavorable Assessment – An unfavorable or adverse assessment by the Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) must set forth the reasons for the conclusion and shall include supporting documentation.
- iv. Completed Application and Assessment – The completed application and written assessment of the Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) -- and the Division Director where applicable -- shall be forwarded to the Credentials Committee for review and recommendation at its next regularly scheduled meeting.

3.3.8 Credentials Committee Review and Recommendation

- a. Process for Review – Upon receipt of the completed application, the Credentials Committee shall:
 - i. review the applicant's character and qualifications;
 - ii. review the application and any assessments in reference to the factors set forth in Section 3.2 and other pertinent criteria; and
 - iii. within thirty (30) days, submit a written report of its findings and recommendations to the Medical Executive Committee.

If the Credentials Committee requires further information, it may defer submitting its report and must notify the applicant, the Department Chief, and the President of the Medical Staff in writing of the deferral and the grounds for such

- h. any involvement as a defendant in any malpractice or professional liability lawsuit during the preceding ten (10) years;
- i. any substance abuse issues, and physical or mental health conditions that may adversely impact the ability to perform requested clinical privileges;
- j. any current misdemeanor or felony criminal charges pending against the applicant, and any past misdemeanor or felony charges, including the resolution of such charges; and
- k. any current or pending state or federal investigation.

3.2.8 **Authorization to Obtain Information** – The applicant shall be required to sign a statement authorizing the Hospital to obtain and review information concerning his/her qualifications for Medical Staff membership from any source, and releasing from liability any party that in good faith provides such information. This authorization shall include permission for the Hospital to conduct a criminal background check. The information provided in the application, including but not limited to the applicant's licensure, specific training, experience, and current competence, shall be verified. The Hospital will seek from the National Practitioner Data Bank all information in its possession about each applicant.

3.2.9 **Consideration of Resources** – In acting upon an application, consideration shall be given to the ability of the Hospital to provide adequate facilities and support services for the applicant and his/her patients, as well as to patient care requirements of Staff Members with the applicant's qualifications. Factors to be considered are:

- a. the extent of the Hospital's needs and available resources in the applicant's specialty;
- b. whether the applicant's specialty is adequately represented on the Medical Staff as determined by the Board;
- c. whether the applicant possesses special competence which would enhance or complement the work of the department to which he/she is applying; and
- d. whether the applicant is willing and qualified to contribute to teaching, research or clinical practice at the Hospital.

3.2.10 **Policy of Non-Discrimination** – Criteria for Medical Staff membership shall be uniformly applied to all applicants. Gender, sexual orientation, race, creed, color, religion, and national origin shall not be considered.

3.2.11 **Discretion of Board** – Any qualifications, requirements, or limitations in this Article which are neither required by law nor by any governmental regulation, may be waived on the recommendation and approval of the Board, upon determination that such waiver will serve the best interests of the Hospital and its patients.

3.3 **Initial Appointment: Procedure**

- 3.3.1 **No Contractual Relationship** – Under no circumstances shall these Bylaws, or the appointment or reappointment process discussed herein, create a contractual relationship between the applicant and the Medical Staff or the Hospital. Furthermore, no contractual rights for an applicant, or any contractual obligations for the Medical Staff or the Hospital, shall be created hereunder.
- 3.3.2 **Timing of Application Review** – All individuals and groups required to act on an application for Medical Staff appointment should do so in a timely and good faith manner. The specified review time periods shall not create any rights for a practitioner to have an application processed within the precise periods.
- 3.3.3 **Pre-Application** – A request for an application to the Medical Staff must be submitted to the Office of Medical Staff Services. In response, a pre-application form may be forwarded to the practitioner requesting information to determine eligibility for a Medical Staff application. The information requested may include the following:
- a. office and residence address;
 - b. staff category and clinical department requested;
 - c. extent of anticipated practice at the Hospital;
 - d. current/anticipated Medical Staff appointments and hospital affiliations; and
 - e. copies of the following documents, as applicable:
 - i. current active, unrestricted license to practice
 - ii. federal Drug Enforcement Agency and Rhode Island controlled substances registration
 - iii. proof of professional liability insurance
 - iv. proof of successful completion of residency training program
 - v. proof of current board certification
- 3.3.4 **Application** – An application for Medical Staff membership will be made available electronically or forwarded to the applicant on a prescribed form.
- a. The application shall state the education, experience, current medical, dental and other professional licensures, permits or certifications, and Drug Enforcement Administration and other controlled substance registrations, and professional references of the applicant.
 - b. The application shall contain a request for the department, staff category, and specific clinical privileges being sought. Criteria for the delineation of clinical privileges shall be developed by the appropriate department, through its Chief. Evaluations of requests for clinical privileges shall be based on information in the

CURRENT RIH BYLAWS RE: CREDENTIALS COMMITTEE

3.3.8 Credentials Committee Review and Recommendation

Final 11/2019

a. Process for Review - Upon receipt of the completed application, the Credentials Committee shall:

- i. review the applicant's character and qualifications;
- ii. review the application and any assessments in reference to the factors set forth in Section 3 .2 and other pertinent criteria; and
- iii. within thirty (30) days, submit a written report of its findings and recommendations to the Medical Executive Committee.

If the Credentials Committee requires further information, it may defer submitting its report and must notify the applicant, the Department Chief, and the President of the Medical Staff in writing of the deferral and the grounds for such

deferral.

b. Process for Additional Information - In the event the Credentials Committee requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Office of Medical Staff Services shall provide the applicant with Special Notice. The notice must state with specificity the additional information being sought and that the applicant has ten (10) days in which to respond. Failure to respond in a satisfactory manner within this timeframe, without good cause, may be deemed a voluntary withdrawal of the application.

Exhibit 44I

CREDENTIALING PROCEDURES MANUAL

Emma Pendleton Bradley
Hospital

March 2017
Revised 1.2020

MEDICAL STAFF CREDENTIALING PROCEDURES MANUAL

The framework of the credentialing process is delineated in the Bylaws Manual Articles II, III and IX. The Credentialing Procedures Manual outlines some of the specific administrative details pertinent to the process.

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PART ONE: APPOINTMENT PROCEDURES

1.1 Pre-Application

Prior to releasing an application to any candidate, a pre-application form is sent to the candidate to determine eligibility to the Medical Staff or APP staff by the Medical Staff Office. The following information is solicited:

- a. office and residence address;
- b. staff category and clinical department requested;
- c. extent of anticipated practice at the Hospital;
- d. current/anticipated Medical Staff appointments and hospital affiliations; and
- e. copies of the following documents, as applicable:
 - i. current active, unrestricted license to practice
 - ii. federal Drug Enforcement Agency and Rhode Island controlled substances registration
 - iii. proof of professional liability insurance
 - iv. proof of successful completion of residency training program
 - v. proof of current board certification

Once the Medical Staff Office determines the candidate is eligible for appointment to the Medical Staff, a complete initial application packet is sent to the candidate.

1.2 Application Content

Every applicant must furnish complete information concerning at least the following: Professional school, and postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended, and names of practitioners responsible for monitoring the applicant's performance.

a. Professional Education and Training Qualifications

Medical Education

An "approved" allopathic medical school is one fully accredited throughout the period of the practitioner's attendance by the Liaison Committee on Medical Education or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

An "approved" osteopathic medical school is one fully accredited throughout the period of the practitioner's attendance by the American Osteopathic Association or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

An "approved" International Medical School is one that is listed in the *World Directory* as meeting eligibility requirements for its students and graduates to apply to ECFMG for ECFMG Certification and examination. The *World Directory* is available at www.wdoms.org. Graduates of these schools must also have a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or, have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Medical Residency Training Programs

An "approved" residency, or preliminary year of training is one fully accredited during the time of the practitioner's training by the Accreditation Council for Graduate Medical Education, or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body. Applicants who do not meet this requirement may be granted a waiver, as detailed in Section 3.8.2 in the Core Bylaws.

Podiatric Education

An "approved" podiatric medical school is one fully accredited throughout the period of the practitioner's attendance by the Council on Podiatric Medical Education or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body. Podiatric medical schools are governed by the American Association of Colleges of Podiatric Medicine (AACPM).

Podiatric Postgraduate Training

An "approved" podiatric residency is one fully accredited by the Council on Podiatric Medical Education during the time of the practitioner's training.

Dental Education

An "approved" school is one fully accredited throughout the period of the practitioner's attendance by the Commission on Dental Accreditation or by a predecessor or successor agency or by an equivalent professionally recognized accrediting body.

Dental Postgraduate Training

An "approved" postgraduate training program is one fully accredited during the time of the practitioner's training by the Commission on Dental Accreditation, or by a predecessor or successor agency or by an equivalent professionally recognized accrediting body.

Psychological Education and Training

A "recognized" graduate program in psychology is one fully accredited during the time of the practitioner's training by the American Psychological Association. A clinical internship in psychology is one accredited by the American Psychological Association. Accredited doctoral programs, internship and post-graduate residencies may be found on the APA Website:

http://apps.apa.org/accredsearch/?_ga=1.99974169.669107786.1464380096

- b. All past and all currently valid medical, dental and other professional licensures, permits or certifications, and Federal Drug Enforcement Administration (DEA) and other controlled substances registrations, with the date and number of each.
- c. Specialty or sub-specialty board certification, recertification, or eligibility status to sit for the examination. Each specialty will adhere to the eligibility rules set forth by the respective specialty board.
 - 1) Recognized Boards
 - a) Board Certification for allopathic and osteopathic physicians shall be in accordance with one of the boards recognized by the American Board of Medical Specialties.
 - b) Board Certification in dentistry shall be in accordance with any Dentistry specialties such as the American Board of Oral and Maxillofacial Surgery, the American Board of Periodontology, or the American Board the Pedodontists. General Dentists are not required to become Board Certified.
 - c) Board Certification in podiatric medicine shall be in accordance with one of the following specialty boards recognized by the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery.

- 2) Board Eligibility - According to the Bylaws, upon appointment to the Medical Staff, a Medical Staff Member who is Board Eligible shall be required to register and take the next board examination for which he/she is eligible. The duration of process to become Board Certified varies by Board and specialty. See Appendix A for descriptions of the Board Certification processes by Specialty.
 - 3) Maintenance of Certification and Recertification – Requirements for maintaining Board Certification, as well as expiration dates for Certification varies by Board and by Specialty. See Appendix A for descriptions of MOC processes.
- d. Health status attestation including substance abuse issues, physical or mental health conditions, and requirements of Rhode Island statutes/regulations regarding healthcare workers.
- 1) Impairment Disclosure
When suspicion or knowledge of an ethical, medical, or behavioral problem is reported, a practitioner may be required to provide such information or to obtain such examination or tests as requested by the Medical Executive Committee. Such examinations shall be performed by a practitioner(s) designated by the Medical Executive Committee.
 - i. Physical or Behavioral Health Impairment: To be free of, or have under adequate control, any physical or behavioral health impairment that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to exercise requested clinical privileges or work cooperatively with others.
 - ii. Substance Abuse Disorder: To be free from abuse of any type of substance that affects cognitive or motor skills or interferes with the ability to exercise requested clinical privileges or work cooperatively with others. A practitioner may be required to submit to on-the-spot testing on the basis of physical manifestations on the job, suspicion based on recent performance, or as follow-up or concurrent monitoring of participation in a treatment program.
- e. Professional liability insurance coverage and information on malpractice claims history and experience (suits and settlements made, concluded and pending), including the names and addresses of present insurance carriers and insurance carrier(s) for the past ten years including Internship, Residency and Fellowship as applicable.
- f. Any pending or completed action involving denial, revocation, suspension, reduction, limitation, or probation of any of the following, and any non-renewal or relinquishment of or withdrawal of an application for any of the following to avoid investigation or possible disciplinary or adverse action.
- 1) License or certificate to practice any profession in any state or country
 - 2) Drug Enforcement Administration or other controlled substances registration
 - 3) Membership or fellowship in local, state or national professional organizations
 - 4) Faculty membership at any medical or other professional school
 - 5) Appointment or employment status, prerogatives or clinical privileges at any other hospital, clinic or health care institution or organization
 - 6) Professional liability insurance
 - 7) Medicare and/or Medicaid participation
- g. Hospital Affiliation and Work/Practice History: Applicants must submit every practice location since graduation from professional/Medical School. Documentation must include location of offices; names and addresses of other practitioners with whom the applicant is or was associated and

inclusive dates of such association in month/year format; names and locations of all other hospitals, clinics or health care institutions or organizations where the applicant provides or provided clinical services with the inclusive dates of each affiliation in month/year format, status held, and general scope of clinical privileges.

- h. Department/Division assignment, Medical Staff category, and specific clinical privileges requested.
- j. Any current criminal charges pending against the applicant and any past charges including their resolution.
- k. Required peer references.
- l. Evidence of the applicant's agreement with the confidentiality, immunity, and release provisions of the Medical Staff Bylaws and related manuals.
- m. Signed Medical Staff Code of Conduct Attestation Sheet
- n. Other elements required by Hospital or health system policy such as confidentiality statements, HIPAA compliance attestation, and Information System Security items.
 - 1) Criminal Background Check Release Form
 - 2) HIPAA Security Policy (IS 209)
 - 3) Patient Safety Policy
 - 4) HIPAA Privacy Policy Attestation
 - 5) Medicare/CHAMPUS Physician Acknowledgment
 - 6) Lifespan Confidentiality Statement Attestation
 - 7) Corporate Compliance Program Attestation
 - 8) Policy Regarding Interaction with Industry Representatives from the Pharmaceutical, Medical Device and Medical Supply Industries - Attestation
 - 9) EMTALA Policy
- o. Identification verification as referenced by The Joint Commission Standards, MS06.01.03 EP5
- p. Immunization records as mandated by the Rhode Island Department of Health for Healthcare workers.
- q. Documentation of physician coverage for applicants requesting admitting privileges.
- r. Explanation and details on any gaps in excess of thirty days within career progression since graduation from professional/Medical School.
- s. Detailed descriptions of any post-graduate training specialty and/or program changes within the same institution or not.

1.3 Special Considerations – Staff Category

1.3-1 Courtesy Staff

- a) Obligations. Bylaws Section 2.3.4 stipulates that Courtesy Staff members may be required to fulfill one or more of the Active Staff obligations under extraordinary circumstances. If a Department Chair needs to invoke any of these obligations for a Courtesy Staff member(s), he/she shall forward the plan with extenuating circumstances and time frame to the Medical Executive Committee for approval.

In the event that immediate action is necessary, the Officers of the Medical Staff shall review and act upon the Department Chair's plan until the next meeting of the full Medical Executive Committee.

- b) Volume. A Courtesy Staff member will be requested to change his/her staff category to Active and meet all obligations of the Active Staff category if he/she admits or provides services on the average to more than 15 patients in any 12-month period.

The following exceptions to these volume considerations apply (in addition to the coverage stipulation noted in the Bylaws):

1. When it can be demonstrated that the excess volume occurred because of a unique set of circumstances that are unlikely to continue or occur again.
2. For circumstances that are related to coverage purposes only.

1.3-2 Doctoral Staff

Candidates to the Doctoral staff need to be credentialed and privileged if the provider engages in patient interaction that includes treatment protocols and/or uses information for clinical conclusions and care of patients. MSS is advised to seek guidance from the appropriate CMO(s) with questions related to whether a particular candidate should be privileged or not.

1.3-3 Research Scientists

Research Scientists should be credentialed if the research being conducted includes any patient interaction or if the research project comes under the auspices of the IRB (human studies). MSS is advised to seek guidance from the CMOs and Research Administration with questions related to credentialing.

1.4 Application Fees

The Medical Executive Committee, with input and endorsement by Hospital Administration will determine application fees for appointment and reappointment. The fee schedule will be maintained in the Medical Staff Services Office. The application fee must accompany the submitted application and is non-refundable. The application will not be deemed complete until the application fee is received.

1.5 References

The application must include the names of at least three (3) professional references. For applicants in the Associate and Research Scientist categories, one (1) professional reference is required. The named individuals must have equivalent licensure and have had extensive experience in observing and working with the applicant professionally within the past year and can attest to current clinical competency, ethical character, and ability to work cooperatively with others, and who will provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. Members of the current/potential practice group may only be used for 1 reference. Training colleagues, the Chief of the RIH or TMH Department to which applicant is applying to or family members and significant others **may NOT** serve as references. At least one reference must practice in the applicant's clinical specialty.

The references will be asked to provide written comments on the following specific areas:

- Medical/Clinical Knowledge
- Technical and Clinical Skills
- Clinical Judgment
- Interpersonal Skills
- Communication Skills
- Professionalism

1.6 Effect of Application

The applicant must sign the application and in so doing:

- a) Attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or termination from the Staff without recourse to the procedural rights;
- b) Agrees to notify the Medical Staff Services Office of any change made or proposed in the status of his/her professional license or permit to practice, Federal DEA or other controlled substances registration, malpractice insurance coverage, membership, employment status or clinical privileges at other institutions/facilities/organizations, and on the status of current or initiation of new malpractice claims;
- c) Agrees to abide by the terms and elements of Bylaws Manual Article III.

1.7 Processing the Application

1.7-1 Applicant's Burden

- a) The applicant has the burden to produce adequate information for a proper evaluation of his/her experience, training, current competence, utilization practice patterns, Continuing Medical Education (CME), and peer references. It is the applicant's responsibility to resolve any doubts about these or any of the qualifications required for Medical Staff appointment or the requested Medical Staff category, Department or Section assignment, or clinical privileges, and to satisfy reasonable requests for information or clarification made by appropriate Staff or Board authorities.
- b) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 90 days after the individual has been notified of the additional information required may be deemed to be withdrawn. If an applicant is responsive to requests from the Medical Staff Office, an application may remain open for up to one (1) year. The individual seeking appointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- c) Personal interviews may be requested by a Department or the Credentials Committee and conducted as appropriate.

1.7-2 Verification of Information

The completed application is submitted to the Medical Staff Services Office and the applicable Department Chairs and Sections Chiefs are notified of its receipt.

The Medical Staff Services Office personnel will conduct primary source verification of the following items:

- a) Any professional license or certification in the state of Rhode Island and any other states where licensure has ever been held
- b) Education including, professional, ECFMG (if applicable)
- c) Training including internship, residency, fellowship (both clinical and research)

- d) Board Certification
- e) Liability coverage and malpractice claims for past 10 years. All found claims, regardless of outcome, will be reviewed by Lifespan's Risk Management Department.
- f) Prior affiliations, work history since graduation of professional/Medical School
- g) Physician/group coverage plan for applicants requesting admitting privileges
- h) Nationwide Criminal Background Screening

Direct submission of written peer references qualifies as primary source verification that can be used when determining current clinical competence. Additional evaluations from external Department Chiefs will be solicited as applicable.

In addition, Medical Staff Services Office personnel will query the National Practitioner Data Bank (NPDB) and OIG and SAM (Excluded Parties List for Medicare/Medicaid).

Applicants will be promptly notified by telephone, mail, or electronic mail of any inconsistencies that arise during the application verification process. If a response has not been received by the tenth day following such notification, a second notification shall be given. This notice will indicate the nature of the additional information the applicant is to provide within a specified time frame. Failure without good cause, to respond in a satisfactory manner by that date may be deemed a voluntary withdrawal of the application.

The list of clinical privileges requested will be sent to all clinical affiliations since graduation to obtain specific information regarding the applicant's experience and competence in exercising each of the privileges requested. Ideally, such verification should address at least the following two specific aspects of current competence:

- (a) For applicants requesting privileges that are surgical or invasive in nature, the number and types of surgical procedures performed as the surgeon of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes. In the case of applicants in nonsurgical fields, the number and types of privileges held to manage the medical conditions by the applicant as the responsible practitioner will be requested. This information may be requested directly from the applicant if not provided by prior facilities.
- (b) The applicant's clinical judgment and technical skills.

Once verification is accomplished, the Medical Staff Services Office will initiate the application review process by informing those involved that the application and all supporting materials are available for review.

1.7-3 Content of Assessments and Bases for Recommendations and Actions

The assessment of each individual or group required to review an application and act on it, must include recommendations for approval, denial, and/or any special limitations on the Medical Staff appointment, staff category, Department and/or Section affiliation, and requested clinical privileges. All documentation and information received by any individual or group during the evaluation process must be included with the application as part of the individual's central credentials file and must be transmitted with the reports and recommendations, as appropriate or requested. The reasons for each recommendation or action to deny, restrict or otherwise limit credentials must be stated, with reference to the completed application and all documentation considered. The report recommendations must be based on the individual's professional qualifications, the individual's ability to deliver quality patient

care in an efficient manner, the demonstrated Hospital and community need for the services, the Hospital's capabilities of supporting the requested privileges, and the individual's ability to have qualified coverage of the care requested.

PART TWO: INDIVIDUALIZED PROFESSIONAL PRACTICE EVALUATION PROCESS

2.1 FPPE

All initial applicants in all staff categories with privileges will undergo a Focused Professional Practice Evaluation (FPPE). Applicants are proctored utilizing one or more of the following as part of the FPPE process:

- Concurrent proctoring: real-time observation of a procedure (*Applicable to: performance of procedures. Minimum Standard: Observation of initial three (3) operative/procedural cases*)
- Retrospective proctoring: review of a case after care has been completed, which may include interviews with personnel involved in the care of the patient.

During the review process of initial applications, the Department Chair, or designee will identify a proctor name and proctoring type, as described above, on the recommendation page in the credentialing packet. Upon Board of Trustee approval to the Medical Staff, the Medical Staff Office communicates directly with the newly appointed member outlining the FPPE policy and process, and provides the appropriate proctoring document(s). The communication states the BOT approval date and that the first cases at the facility should be proctored. It is the applicant's responsibility to coordinate with the proctor to have the proctoring forms completed. The completed forms are then returned to the Medical Staff Office. Once completed proctoring forms are returned, a FPPE review packet is prepared for the department chief which include the completed proctoring forms. After Department Chair approval, successful completion of the FPPE is documented in the Medical Staff credentialing software, and the member is notified when the FPPE period is concluded. Outcome summaries of FPPE review reports are also submitted to the Credentials Committee.

Refer also to the FPPE policy Bradley Hospital Administrative Policy Manual and TJC standard MS08.01.01.

There are occasions during the initial applicant review process that a specific enhanced FPPE program is requested, by either Department or the Credentials Committee. In these situations, the Medical Staff Office, documents the specifics of the FPPE plan, notifies the proctor and the department chief of the details of the FPPE as well as the applicant. The Medical Staff Office then tracks the completion of the specific program and provides reports to the Credentials Committee as requested.

2.2 OPPE

All applicants with privileges, including initial applicants, participate in the Ongoing Professional Practice Evaluation (OPPE) process. Each department, in collaboration with the OpX department, establishes criteria on which to base the OPPE analysis. Data is summarized and reviewed by the Department Chair, or an approved delegated medical staff leader, consistent with the OPPE policy in effect at the time.

Refer also to the System-wide OPPE policy #Admin160 and TJC standard MS08.01.03.

PART THREE: REAPPOINTMENT PROCEDURES

3.1 Information Collection and Verification

Reappointment applications are distributed 6 months in advance of the appointment cycle expiration date. Applicants are requested to return the reappointment application and supporting documentation approximately 5 months ahead of the cycle end date.

3.1-2 Timeliness of applicant response

Rarely, an applicant will not return an application and supporting documentation in a timely manner, despite repeated notifications and reminders by MSS, and a lapse in privileges occurs (not in relation to an LOA). If the duration of the privileges is 1 day to 6 months after the deadline, the provider will need to complete the reappointment application and pay the initial application fee of \$275.

3.1-3 Types of Information Obtained

The Medical Staff Services Office collects all relevant information regarding the individual's professional and collegial activities, performance and conduct in this Hospital. Such information, which together with the information obtained from the applicant and other external sources shall form the basis for recommendations and action. These shall include, without limitation:

- (a) Clinical performance and patterns of care as demonstrated in the findings of direct observation, quality assessment and improvement, risk management and utilization management activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (where available), provided that other practitioners shall not be identified. This information will include data obtained through the OPPE process over the last 4 semi-annual reporting periods. (Refer also to the System-wide OPPE policy);
- (b) Participation in relevant continuing education activities;
 - (i) Physician applicants for reappointment must submit documentation of at least 40 hours of American Medical Association (AMA) Category I continuing medical education (CME) credits earned during the preceding two years consistent with Rhode Island medical licensure regulations.
 - (ii) All other practitioners will submit documentation of sufficient CME/CEU to meet the requirements promulgated by their corresponding state licensure board averaged over the two-year appointment interval.
- (c) All applicants will have clinical judgment and technical skills assessed. The level/amount of clinical activity (patient care contacts) at the Hospital will be obtained. These data will be obtained by MSS from OpX or from the provider. MSS will ensure appropriate documentation for all criteria based or volume based privileges.
 - (i) Data for applicants in fields performing surgical or other invasive procedures will include the number and types of procedures performed as the surgeon/proceduralist of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes and patient care management and consultations performed.
 - (ii) Data for applicants for reappointment in nonsurgical fields will include the number and types of medical conditions managed/consulted and the procedures performed by the applicant as the responsible practitioner.

- (d) Sanctions imposed or pending
- (e) Attendance at required Medical Staff, Department, Division, and Committee meetings, as specified by Departmental policy;
- (f) Participation as a Medical Staff official, committee member/Chair and proctor, and in on-call coverage roster;
- (g) Timely and accurate completion and preparation of medical records;
- (h) Cooperativeness in working with other practitioners and Hospital personnel;
- (i) General attitude toward patients and the Hospital;
- (j) Peer Reference(s). The application must include the names of at least two (2) professional references. For applicants in the Associate and Research Scientist categories, one (1) professional reference is required. The named individuals must have equivalent licensure and have had extensive experience in observing and working with the applicant professionally within the past year and can attest to current clinical competency, ethical character, and ability to work cooperatively with others, and who will provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. Members of the current practice group may only be used for 1 reference. Training colleagues, the Chief of the Department to which applicant is applying to or family members and significant others **may NOT** serve as references.
- (k) Compliance with all applicable bylaws, policies, rules, and procedures of the Hospital and Medical Staff;
- (l) Any other pertinent information that may be relevant to the Medical Staff member's status and privileges at this Hospital, including the Medical Staff member's activities at other hospitals and medical practice outside the Hospital.

3.1-4 Volume Considerations

Applicants with limited clinical activity at the Hospital are considered to be low volume providers. Consideration of these providers is outlined in Bylaws 3.6.1c.

Courtesy Staff volume exceptions are noted in Section 1.2-1.

3.1-5 Verification of Information

The Medical Staff Services Office personnel will conduct primary source verification of the following items:

- (a) Any professional license
- (b) Board Certification/recertification
- (c) Additional training cited in the reappointment application
- (d) Liability coverage and claims history (with review and signoff by Risk Management if needed)
- (e) Other hospital affiliations

In addition, the National Practitioner Databank will be queried.

3.2 Aging Practitioners

Upon reappointment for all credentialed providers who have reached the age of 70, and upon each subsequent reappointment, a 360 evaluation, and personal interview will be conducted. A focused professional performance evaluation may be initiated consistent with the Aging Practitioner policy in effect.

3.3 Content of Report and Bases for Recommendations and Action

The report of each individual or group required to act on an application must include recommendations for approval, denial, and/or any special limitations on the Medical Staff appointment, staff category, Department and/or Section affiliation, and requested clinical privileges. All documentation and information received by any individual or group during the evaluation process must be included with the application as part of the individual's central credentials file and must be transmitted with the reports and recommendations, as appropriate or requested. The reasons for each recommendation or action to deny, restrict or otherwise limit credentials must be stated, with reference to the completed application and all documentation considered. The report recommendations must be based on the individual's professional qualifications, the individual's ability to deliver quality patient care in an efficient manner, the demonstrated Hospital and community need for the services, the Hospital's capabilities of supporting the requested privileges, and the individual's ability to have qualified coverage of the care requested.

PART FOUR: DELINEATING CLINICAL PRIVILEGES

4.1 Department Responsibility to Define Approach to Delineating Privileges

Each Department must define, in writing, the conditions, operative, invasive and other special procedures that fall within its clinical area, including levels of severity or complexity, age groupings as appropriate, and the requisite training, experience or other qualifications required. These definitions must be incorporated in the processes used for requesting and granting privileges and must be approved by the Credentials Committee, the Medical Executive Committee, and the Board. The scope and processes must be periodically reviewed and revised as necessary to reflect new procedures, instrumentation, treatment modalities and similar advances or changes.

When processes are revised, by additions or deletions or the adoption of new privilege forms, all Medical Staff members holding privileges in the Department must, complete the new forms, request and be processed for privileges added, or comply with the fact that a privilege was deleted.

4.2 Contractual or Employment Relationships

4.2-1 Medical Staff Appointment

A practitioner who is or who will be providing specified professional services pursuant to a contract/employment with the Hospital must meet the same qualifications for appointment to the Medical Staff, must be evaluated for Medical Staff appointment, reappointment and clinical privileges in the same manner, and must fulfill all of the obligations of the medical staff category as any other applicant for Medical Staff appointment.

4.2-2 Effect of Medical Staff Appointment Termination or Clinical Privileges Restriction

Practice at the Hospital is contingent upon continued Medical Staff membership and is also constrained by the extent of clinical privileges granted.

A practitioner's right to use Hospital facilities is therefore automatically terminated when Medical Staff membership expires or is terminated. Similarly, the extent of practice at the Hospital is automatically limited to the extent that clinical privileges are restricted or revoked.

The effect of an adverse change in clinical privileges on continuation of the contract/employment arrangement is governed solely by the terms of the contract/employment arrangement.

4.2-3 Effect of Contract Expiration or Termination

The effect of expiration or other termination of a practitioner's contract/employment agreement upon the practitioner's Medical Staff membership and clinical privileges will be governed solely by the terms of the contract/employment agreement with the Hospital, if it addresses the issue.

If the contract/employment arrangement is silent on the matter, then expiration or other termination of the contract alone will not affect the practitioner's medical staff membership or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which exclusive contractual arrangements have been made.

4.3 **Medical Administrative Positions**

4.3-1 **Medical Staff Appointment**

Practitioner(s) engaged by the Hospital in a medical administrative capacity, such as Division Directors, whose professional activities may also include clinical responsibilities such as direct patient care or teaching and/or supervision of patient care activities of other practitioners may need achieve and maintain Medical Staff appointment and clinical privileges appropriate to the clinical responsibilities and discharge Medical Staff obligations appropriate to the granted Medical Staff category and in the same manner applicable to all other Medical Staff members. Refer also Article IV of the Medical Staff Bylaws.

4.3-2 **Effect of Medical Staff Appointment Termination or Clinical Privileges Restriction**

Adverse revocation of Medical Staff appointment and all clinical privileges precludes continuing in the medical administrative capacity as applicable.

The adverse revocation of select clinical privileges will initiate review of continued medical administrative service.

4.3-3 **Effect of Contract Expiration or Termination**

Removal or resignation from the medical administrative position alone does not affect the individual's Medical Staff membership or clinical privileges.

PART FIVE: MODIFYING CLINICAL PRACTICE

5.1 Relinquishment of Clinical Privileges

A Medical Staff member or APP who chooses to no longer exercise or to voluntarily restrict or limit the exercise of specific privileges which have previously been granted shall send written notice to the appropriate Department Chair indicating the same and identifying the particular privileges involved and applicable restrictions or limitations. This request for a change in privileges shall be routed for review as outlined in Section 3.3.7 – 3.3.10 of the Bylaws. Documentation of the change of privileges is included in the member's credentials file.

5.2 Increase in Clinical Privileges

A Medical Staff member who wishes to request additional specific privileges which have not previously been granted shall send written notice to the appropriate Department Chair or Medical Staff Office indicating the same and identifying the particular privilege(s) involved. MSS will obtain the following information from the applicant:

1. Letter of Intent (reason for the request)
2. Updated Privilege/Patient Care Services form (if applicable)
3. Supporting Clinical Activity/Patient encounters in support of increase of privileges
4. Updated malpractice insurance certificate (if applicable)
5. Group Coverage List and Verification (if applicable)

A completed change of status packet will be routed for review as outlined in Section 3.3.7 – 3.3.10 of the Bylaws. Documentation of the change of privileges will be included in the member's credentials file.

Once the change of privileges has been approved, the applicant will be notified to complete the FPPE process as outlined in Part II above; and all data systems will be updated as appropriate.

5.3 Modification of Practice Status

A Medical Staff member who plans to make a significant change in his/her practice situation shall send advanced written notice to the appropriate Department Chair or Medical Staff Services indicating the particulars of the change. Examples include leave of absence, resignation, retirement, changes in practice location, changes in practice association, and changes in employment relationship with the hospital. When MSS receives notice of changes in practice status from other sources, changes will be verified with the practitioner prior to documenting the change in status in MSS credentialing database(s).

Depending on the nature of the change, MSS will update appropriate data systems per policy and practice. Resignations, including the reason for the resignation, are documented in the Credentials Committee Report for review by the MEC and BOT.

5.3-1 Leaves of Absence

Circumstances that require notification to MSS include long term sabbatical type leaves and health related leaves that would potentially impact one's ability to provide care in the long term. Short term health related situations, e.g. pregnancy, recovery from a non-debilitating injury, etc, do not require that a formal leave of absence be initiated. Should MSS have questions regarding whether a practitioner needs to be placed on a formal LOA per the bylaws, MSS will contact the appropriate Department Chief and/or CMO for guidance and resolution.

An LOA cannot alter the appointment cycle of the practitioner. MSS will communicate to Chiefs and Practitioners on a LOA that the reappointment process takes 60-90 days to ensure providers understand the timeframe involved in the reappointment process to assist in avoiding lapses in privileges. MSS will also notify the Chief and practitioner that a re-appointment can be processed early to prevent a lapse in privileges.

PART SIX: SPECIAL PRIVILEGING PROCEDURES**6.1 Granting Temporary Privileges**

The process for granting temporary privileges is described in the Core Bylaws. MSS facilitates communication between Department Chief, CMO, Medical Staff President, Credentials Committee Chair and Hospital President to document the approval process, and notifies the applicant of the final outcome in writing.

6.2 Procedure for Granting Disaster Privileges**6.2-1 Conditions**

In addition to the Bylaws Manual provisions regarding Disaster Privileges, volunteer practitioners will be teamed with Medical Staff members to permit direct observation of care rendered and provide monitoring opportunities and procedural guidance. As circumstances permit or dictate, clinical record reviews will be undertaken to ensure quality of care rendered.

All grants of disaster privileges shall reflect the individual's training and specialty.

PART SEVEN: ADVANCED PRACTICE PROFESSIONALS

7.1 Definition

As defined in Bylaws Article IX, Advanced Practice Professionals (APPs) shall include designated independent and non-independent health care professionals who are qualified by formal training, licensure, and current competence in a health care discipline which the Board of Trustees has approved for practice within the Hospital's scope of services. There are 2 Staff Categories: APP, which is for those practitioners who need privileges at a Lifespan owned and operated facility; and 2) Associate APP, which is for those who do not want privileges to provide care at a Lifespan owned and operated facility, but want/need affiliation with a Lifespan hospital.

7.2 Eligible Practitioners

The specific disciplines include:

Nurse Practitioner

Qualified Mental Health Professional

Masters Level psychologist or other clinician who meets the criteria as established by the RI Mental Health Law

LICSW

Psychiatric Nurse Clinician

7.3 Qualifications

A statement of qualifications for each category of APP shall be developed for review by the Credentials Committee, subject to approval by the Board. Each such statement must:

- (a) Be developed with input, from the Chief of the applicable Department(s), and other key stakeholders; and
- (b) Require that the individual APP hold a current license, certificate or such other credential, as may be required by Rhode Island law to exercise the privileges or provide the services being requested; and
- (c) Be delineated on each individual privilege form.

7.4 Prerogatives and Obligations

Prerogatives are listed in the Bylaws.

Each Advanced Practice Professional is obligated to the following:

- (a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate Hospital facilities.
- (b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services and, when

necessary and as appropriate to the circumstances of the case, either arrange or alert the principal attending physician of the need for a suitable alternative for such care and supervision.

- (c) Participate when requested in quality review and risk management program activities and in such other functions as may be required from time to time.
- (d) Attend clinical and educational meetings of the Medical Staff and of the Department or Section and any other clinical units with which affiliated.
- (e) May be appointed to serve on Medical Staff Committees and may also be invited to specified Medical Staff meetings, but only at the pleasure of the invitation of the Medical Staff President.
- (f) Abide by the Medical Staff Bylaws and related manuals, the Hospital Bylaws, and all other standards, policies and rules of the Medical Staff and Hospital.
- (g) Prepare and complete in a timely fashion as required in the Medical Staff Rules and Regulations those portions of patients' medical records documenting services provided and any other required records.
- (h) Refrain from any conduct or acts that are or could be reasonably interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

7.5 Scope of Privileges and Service Description

Notwithstanding the apparent scope of practice permitted to any group of Advanced Practice Professional under Rhode Island law or licensure, the scope of privileges and guidelines described above may place limitations on the scope of practice authorized in the Hospital as deemed necessary for the efficient and effective operation of the Hospital or any of its departments or services; for management of personnel, services and equipment; for quality or efficient patient care; or as otherwise deemed by the Board to be in the best interests of patient care in the Hospital.

The scope of practice or granted patient care services available to any group of Advanced Practice Professional shall be developed with input from the appropriate Department Chairs and Section Chiefs, as applicable, and representatives of management. The scope and description of patient care services will be reviewed by the Credentials Committee and recommended for approval to the MEC and BOT. The scope is subject to the approval of the Board.

7.6 Subcategories of Advanced Practice Professionals

As noted in Section 7.1, the Advanced Practice Professionals designation includes designated independent and non-independent health care professionals.

7.6-1 Independent Advanced Practice Professionals

An Independent Advanced Practice Professional is an individual who fulfills the criteria in Bylaws Article IX but is permitted by the Hospital to provide services independently in the Hospital, i.e., without the direction or immediate supervision of a physician, and is not required to have documentation countersigned.

Current policy permits the following types of Advanced Practice Professionals to provide independent services in the Hospital:

Advanced Practice Nurse
Masters Level psychologist or other clinician who meets the criteria as established by the RI
Mental Health Law
LICSW

7.6-2 Non-independent Advanced Practice Professionals

A Non-independent Advanced Practice Professional is an individual who is qualified by licensure, certification, or academic and/or clinical training and current competence to function in a medical support role to, and under the direction and supervision of, a practitioner and who is in a health care discipline which the Board has approved to practice in the Hospital.

Current policy permits the following types of Advanced Practice Professionals to provide non-independent services in the Hospital:

Qualified Mental Health Professional

Continued affiliation as a Non-independent Advanced Practice Professional is contingent upon maintenance of the employment or contractual relationship with the supervising physician. Termination of this relationship will result in an automatic termination of clinical hospital affiliation. Termination of clinical hospital affiliation for this reason does not entitle the APP to procedural rights to due process.

7.7 Terms and Conditions of Affiliation

Each Advanced Practice Professional shall be assigned to a Department(s), if applicable, appropriate to his/her professional training and is subject to an initial Focused Professional Practice Evaluation utilizing metrics defined by the Department/Division.

An Advanced Practice Professional's provision of specified services within any Department or Division is subject to the rules and regulations of that Department and Section and to the authority of the Department or Division Chief, as applicable. The quality and efficiency of the care provided by APPs within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or Hospital quality review, risk management and utilization management mechanisms.

7.8 Appointment and Re-appointment Procedures

APPs will be subject to the same procedures as defined in Parts 1- 6 of this manual.

PART VIII: EXPIRING CREDENTIALS

8.1 Process

At the beginning of each month, Medical Staff Services identifies from the credentialing data base, all providers who have an expiring credential at the end of that month. Notification is sent to the provider via email (and fax) stating:

“Evidence of current credentialing documentation is a requirement for privileges and/or membership at all Lifespan affiliated hospitals. This letter is to inform you that required documentation will be expiring on the date listed. Medical Staff Services must receive a copy of this documentation prior to the expiration date to avoid any disruption to clinical privileges at a Lifespan affiliated hospital.”

Follow-up occurs every two weeks until credential is received. If the credential is not received that information is brought to the attention of the MSS Managers and clinical leadership if necessary, for further action.

8.2 Types of Expiring Credentials by Applicable Staff Category

Expiring Credentials	Staffing Categories Expiring Credentials are Applicable to
Malpractice Insurance	Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Advanced Practice Professionals
Federal DEA Registration	Active, Senior Active, Courtesy, Consulting, Advanced Practice Professionals (NP & PA only)
State Licensure and Substance Control	Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Advanced Practice Professionals
Advanced Practice Certifications	Advanced Practice Professionals
Privileging Criteria Certifications – ACLS, PALS, Neonatal Certification	Active, Senior Active, Courtesy, Consulting, Advanced Practice Professionals who hold privileges requiring certification
Tuberculosis Testing (RIH/TMH)	Active, Senior Active, Courtesy, Consulting, Doctoral, Advanced Practice Professionals in specific specialties and/or service lines as determined by EOHS.

PART NINE: ADOPTION

9.1 Credentials Committee

This Credentialing Procedures Manual was reviewed and adopted by the Credentials Committee in March 2017.
MEC 2.24.2021

Appendix A

Board Certification and MOC Requirements by Specialty

Exhibit 44G

CREDENTIALING PROCEDURES MANUAL

The Miriam Hospital

March 2017

MEDICAL STAFF CREDENTIALING PROCEDURES MANUAL

The framework of the credentialing process is delineated in the Bylaws Manual Articles II, III and IX. The Credentialing Procedures Manual outlines some of the specific administrative details pertinent to the process.

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PART ONE: APPOINTMENT PROCEDURES

1.1 Pre-Application

Prior to releasing an application to any candidate, a pre-application form is sent to the candidate to determine eligibility to the Medical Staff or APP staff by the Medical Staff Office. The following information is solicited:

- a. office and residence address;
- b. staff category and clinical department requested;
- c. extent of anticipated practice at the Hospital;
- d. current/anticipated Medical Staff appointments and hospital affiliations; and
- e. copies of the following documents, as applicable:
 - i. current active, unrestricted license to practice
 - ii. federal Drug Enforcement Agency and Rhode Island controlled substances registration
 - iii. proof of professional liability insurance
 - iv. proof of successful completion of residency training program
 - v. proof of current board certification

Once the Medical Staff Office determines the candidate is eligible for appointment to the Medical Staff, a complete initial application packet is sent to the candidate.

1.2 Application Content

Every applicant must furnish complete information concerning at least the following: Professional school, and postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended, and names of practitioners responsible for monitoring the applicant's performance.

a. Professional Education and Training Qualifications

Medical Education

An "approved" allopathic medical school is one fully accredited throughout the period of the practitioner's attendance by the Liaison Committee on Medical Education or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

An "approved" osteopathic medical school is one fully accredited throughout the period of the practitioner's attendance by the American Osteopathic Association or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

An "approved" International Medical School is one that is listed in the *World Directory* as meeting eligibility requirements for its students and graduates to apply to ECFMG for ECFMG Certification and examination. The *World Directory* is available at www.wdoms.org. Graduates of these schools must also have a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or, have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Medical Residency Training Programs

An "approved" residency, or preliminary year of training is one fully accredited during the time of the practitioner's training by the Accreditation Council for Graduate Medical Education, or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body. Applicants who do not meet this requirement may be granted a waiver, as detailed in Section 3.8.2 in the Core Bylaws.

Podiatric Education

An "approved" podiatric medical school is one fully accredited throughout the period of the practitioner's attendance by the Council on Podiatric Medical Education or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body. Podiatric medical schools are governed by the American Association of Colleges of Podiatric Medicine (AACPM).

Podiatric Postgraduate Training

An "approved" podiatric residency is one fully accredited by the Council on Podiatric Medical Education during the time of the practitioner's training.

Dental Education

An "approved" school is one fully accredited throughout the period of the practitioner's attendance by the Commission on Dental Accreditation or by a predecessor or successor agency or by an equivalent professionally recognized accrediting body.

Dental Postgraduate Training

An "approved" postgraduate training program is one fully accredited during the time of the practitioner's training by the Commission on Dental Accreditation, or by a predecessor or successor agency or by an equivalent professionally recognized accrediting body.

Psychological Education and Training

A "recognized" graduate program in psychology is one fully accredited during the time of the practitioner's training by the American Psychological Association. A clinical internship in psychology is one accredited by the American Psychological Association. Accredited doctoral programs, internship and post-graduate residencies may be found on the APA Website:

http://apps.apa.org/accredsearch/?_ga=1.99974169.669107786.1464380096

- b. All past and all currently valid medical, dental and other professional licensures, permits or certifications, and Federal Drug Enforcement Administration (DEA) and other controlled substances registrations, with the date and number of each.
- c. Specialty or sub-specialty board certification, recertification, or eligibility status to sit for the examination. Each specialty will adhere to the eligibility rules set forth by the respective specialty board.
 - 1) Recognized Boards
 - a) Board Certification for allopathic and osteopathic physicians shall be in accordance with one of the boards recognized by the American Board of Medical Specialties.
 - b) Board Certification in dentistry shall be in accordance with any Dentistry specialties such as the American Board of Oral and Maxillofacial Surgery, the American Board of Periodontology, or the American Board the Pedodontists.
 - c) Board Certification in podiatric medicine shall be in accordance with one of the following specialty boards recognized by the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery.
 - 2) Board Eligibility - According to the Bylaws, upon appointment to the Medical Staff, a Medical Staff Member who is Board Eligible shall be required to register and take the next

board examination for which he/she is eligible. The duration of process to become Board Certified varies by Board and specialty. See Appendix A for descriptions of the Board Certification processes by Specialty.

- 3) Maintenance of Certification and Recertification – Requirements for maintaining Board Certification, as well as expiration dates for Certification varies by Board and by Specialty. See Appendix A for descriptions of MOC processes.
- d. Health status attestation including substance abuse issues, physical or mental health conditions, and requirements of Rhode Island statutes/regulations regarding healthcare workers.
- 1) Impairment Disclosure
When suspicion or knowledge of an ethical, medical, or behavioral problem is reported, a practitioner may be required to provide such information or to obtain such examination or tests as requested by the Medical Executive Committee. Such examinations shall be performed by a practitioner(s) designated by the Medical Executive Committee.
 - i. Physical or Behavioral Health Impairment: To be free of, or have under adequate control, any physical or behavioral health impairment that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to exercise requested clinical privileges or work cooperatively with others.
 - ii. Substance Abuse Disorder: To be free from abuse of any type of substance that affects cognitive or motor skills or interferes with the ability to exercise requested clinical privileges or work cooperatively with others. A practitioner may be required to submit to on-the-spot testing on the basis of physical manifestations on the job, suspicion based on recent performance, or as follow-up or concurrent monitoring of participation in a treatment program.
- e. Professional liability insurance coverage and information on malpractice claims history and experience (suits and settlements made, concluded and pending), including the names and addresses of present insurance carriers and insurance carrier(s) for the past ten years including Internship, Residency and Fellowship as applicable.
- f. Any pending or completed action involving denial, revocation, suspension, reduction, limitation, or probation of any of the following, and any non-renewal or relinquishment of or withdrawal of an application for any of the following to avoid investigation or possible disciplinary or adverse action.
- 1) License or certificate to practice any profession in any state or country
 - 2) Drug Enforcement Administration or other controlled substances registration
 - 3) Membership or fellowship in local, state or national professional organizations
 - 4) Faculty membership at any medical or other professional school
 - 5) Appointment or employment status, prerogatives or clinical privileges at any other hospital, clinic or health care institution or organization
 - 6) Professional liability insurance
 - 7) Medicare and/or Medicaid participation
- g. Hospital Affiliation and Work/Practice History: Applicants must submit every practice location since graduation from professional/Medical School. Documentation must include location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association in month/year format; names and locations of all other hospitals, clinics or health care institutions or organizations where the applicant provides or provided clinical

services with the inclusive dates of each affiliation in month/year format, status held, and general scope of clinical privileges.

- h. Department/Division assignment, Medical Staff category, and specific clinical privileges requested.
- j. Any current criminal charges pending against the applicant and any past charges including their resolution.
- k. Required peer references.
- l. Evidence of the applicant's agreement with the confidentiality, immunity, and release provisions of the Medical Staff Bylaws and related manuals.
- m. Signed Medical Staff Code of Conduct Attestation Sheet
- n. Other elements required by Hospital or health system policy such as confidentiality statements, HIPAA compliance attestation, and Information System Security items.
 - 1) Criminal Background Check Release Form
 - 2) HIPAA Security Policy (IS 209)
 - 3) Patient Safety Policy
 - 4) HIPAA Privacy Policy Attestation
 - 5) Medicare/CHAMPUS Physician Acknowledgment
 - 6) Lifespan Confidentiality Statement Attestation
 - 7) Corporate Compliance Program Attestation
 - 8) Policy Regarding Interaction with Industry Representatives from the Pharmaceutical, Medical Device and Medical Supply Industries - Attestation
 - 9) EMTALA Policy
- o. Identification verification as referenced by The Joint Commission Standards, MS06.01.03 EP5
- p. Immunization records as mandated by the Rhode Island Department of Health for Healthcare workers.
- q. Documentation of physician coverage for applicants requesting admitting privileges.
- r. Explanation and details on any gaps in excess of thirty days within career progression since graduation from professional/Medical School.
- s. Detailed descriptions of any post-graduate training specialty and/or program changes within the same institution or not.

1.3 Special Considerations – Staff Category

1.3-1 Courtesy Staff

- a) Obligations. Bylaws Section 2.3.4 stipulates that Courtesy Staff members may be required to fulfill one or more of the Active Staff obligations under extraordinary circumstances. If a Department Chair needs to invoke any of these obligations for a Courtesy Staff member(s), he/she shall forward the plan with extenuating circumstances and time frame to the Medical Executive Committee for approval.

In the event that immediate action is necessary, the Officers of the Medical Staff shall review and act upon the Department Chair's plan until the next meeting of the full Medical Executive Committee.

- b) Volume. A Courtesy Staff member will be requested to change his/her staff category to Active and meet all obligations of the Active Staff category if he/she admits or provides services on the average to more than 15 patients in any 12-month period.

The following exceptions to these volume considerations apply (in addition to the coverage stipulation noted in the Bylaws):

1. When it can be demonstrated that the excess volume occurred because of a unique set of circumstances that are unlikely to continue or occur again.
2. For Closed-Staff Service Departments
 - Anesthesiologists
 - Emergency Medicine Physicians
 - Pathologists
 - Radiologists
3. For surgical assistants since they are not primarily responsible for the patient.
4. For circumstances that are related to coverage purposes only.

1.3-2 Doctoral Staff

Candidates to the Doctoral staff need to be credentialed and privileged if the provider engages in patient interaction that includes treatment protocols and/or uses information for clinical conclusions and care of patients. MSS is advised to seek guidance from the appropriate CMO(s) with questions related to whether a particular candidate should be privileged or not.

1.3-3 Research Scientists

Research Scientists should be credentialed if the research being conducted includes any patient interaction or if the research project comes under the auspices of the IRB (human studies). MSS is advised to seek guidance from the CMOs and Research Administration with questions related to credentialing.

1.4 Application Fees

The Medical Executive Committee, with input and endorsement by Hospital Administration will determine application fees for appointment and reappointment. The fee schedule will be maintained in the Medical Staff Services Office. The application fee must accompany the submitted application and is non-refundable. The application will not be deemed complete until the application fee is received.

1.5 References

The application must include the names of at least three (3) professional references. For applicants in the Associate and Research Scientist categories, one (1) professional reference is required. The named individuals must have equivalent licensure and have had extensive experience in observing and working with the applicant professionally within the past year and can attest to current clinical competency, ethical character, and ability to work cooperatively with others, and who will provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. In most cases, members of the current/potential practice group, training colleagues, the Chief of the RIH or TMH Department to which applicant is applying to or family members and significant others **may NOT** serve as references. At least one reference must practice in the applicant's clinical specialty.

The references will be asked to provide written comments on the following specific areas:

- Medical/Clinical Knowledge
- Technical and Clinical Skills

- Clinical Judgment
- Interpersonal Skills
- Communication Skills
- Professionalism

1.6 Effect of Application

The applicant must sign the application and in so doing:

- a) Attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or termination from the Staff without recourse to the procedural rights;
- b) Agrees to notify the Medical Staff Services Office of any change made or proposed in the status of his/her professional license or permit to practice, Federal DEA or other controlled substances registration, malpractice insurance coverage, membership, employment status or clinical privileges at other institutions/facilities/organizations, and on the status of current or initiation of new malpractice claims;
- c) Agrees to abide by the terms and elements of Bylaws Manual Article III.

1.7 Processing the Application

1.7-1 Applicant's Burden

- a) The applicant has the burden to produce adequate information for a proper evaluation of his/her experience, training, current competence, utilization practice patterns, Continuing Medical Education (CME), and peer references. It is the applicant's responsibility to resolve any doubts about these or any of the qualifications required for Medical Staff appointment or the requested Medical Staff category, Department or Section assignment, or clinical privileges, and to satisfy reasonable requests for information or clarification made by appropriate Staff or Board authorities.
- b) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 90 days after the individual has been notified of the additional information required may be deemed to be withdrawn. If an applicant is responsive to requests from the Medical Staff Office, an application may remain open for up to one (1) year. The individual seeking appointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- c) Personal interviews may be requested by a Department or the Credentials Committee and conducted as appropriate.

1.7-2 Verification of Information

The completed application is submitted to the Medical Staff Services Office and the applicable Department Chairs and Sections Chiefs are notified of its receipt.

The Medical Staff Services Office personnel will conduct primary source verification of the following items:

- a) Any professional license or certification in the state of Rhode Island and any other states where licensure has ever been held
- b) Education including, professional, ECFMG (if applicable)
- c) Training including internship, residency, fellowship (both clinical and research)
- d) Board Certification
- e) Liability coverage and malpractice claims for past 10 years. All found claims, regardless of outcome, will be reviewed by Lifespan's Risk Management Department.
- f) Prior affiliations, work history since graduation of professional/Medical School
- g) Physician/group coverage plan for applicants requesting admitting privileges
- h) Nationwide Criminal Background Screening

Direct submission of written peer references qualifies as primary source verification that can be used when determining current clinical competence. Additional evaluations from external Department Chiefs will be solicited as applicable.

In addition, Medical Staff Services Office personnel will query the National Practitioner Data Bank (NPDB) and OIG and SAM (Excluded Parties List for Medicare/Medicaid).

Applicants will be promptly notified by telephone, mail, or electronic mail of any inconsistencies that arise during the application verification process. If a response has not been received by the tenth day following such notification, a second notification shall be given. This notice will indicate the nature of the additional information the applicant is to provide within a specified time frame. Failure without good cause, to respond in a satisfactory manner by that date may be deemed a voluntary withdrawal of the application.

The list of clinical privileges requested will be sent to all clinical affiliations since graduation to obtain specific information regarding the applicant's experience and competence in exercising each of the privileges requested. Ideally, such verification should address at least the following two specific aspects of current competence:

- (a) For applicants requesting privileges that are surgical or invasive in nature, the number and types of surgical procedures performed as the surgeon of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes. In the case of applicants in nonsurgical fields, the number and types of privileges held to manage the medical conditions by the applicant as the responsible practitioner will be requested. This information may be requested directly from the applicant if not provided by prior facilities.
- (b) The applicant's clinical judgment and technical skills.

Once verification is accomplished, the Medical Staff Services Office will initiate the application review process by informing those involved that the application and all supporting materials are available for review.

1.7-3 Content of Assessments and Bases for Recommendations and Actions

The assessment of each individual or group required to review an application and act on it, must include recommendations for approval, denial, and/or any special limitations on the Medical Staff appointment, staff category, Department and/or Section affiliation, and requested clinical privileges. All

documentation and information received by any individual or group during the evaluation process must be included with the application as part of the individual's central credentials file and must be transmitted with the reports and recommendations, as appropriate or requested. The reasons for each recommendation or action to deny, restrict or otherwise limit credentials must be stated, with reference to the completed application and all documentation considered. The report recommendations must be based on the individual's professional qualifications, the individual's ability to deliver quality patient care in an efficient manner, the demonstrated Hospital and community need for the services, the Hospital's capabilities of supporting the requested privileges, and the individual's ability to have qualified coverage of the care requested.

PART TWO: INDIVIDUALIZED PROFESSIONAL PRACTICE EVALUATION PROCESS

2.1 FPPE

All initial applicants in all staff categories with privileges will undergo a Focused Professional Practice Evaluation (FPPE). Applicants are proctored utilizing one or more of the following as part of the FPPE process:

- Concurrent proctoring: real-time observation of a procedure (*Applicable to: performance of procedures. Minimum Standard: Observation of initial three (3) operative/procedural cases*)
- Retrospective proctoring: review of a case after care has been completed, which may include interviews with personnel involved in the care of the patient.

During the review process of initial applications, the Department Chief, or designee will identify a proctor name and proctoring type, as described above, on the recommendation page in the credentialing packet. Upon Board of Trustee approval to the Medical Staff, the Medical Staff Office communicates directly with the newly appointed member outlining the FPPE policy and process, and provides the appropriate proctoring document(s). The communication states the BOT approval date and that the first cases at the facility should be proctored. It is the applicant's responsibility to coordinate with the proctor to have the proctoring forms completed. The completed forms are then returned to the Medical Staff Office. Once completed proctoring forms are returned, a FPPE review packet is prepared for the department chief which include the completed proctoring forms. After Department Chair approval, successful completion of the FPPE is documented in the Medical Staff credentialing software, and the member is notified when the FPPE period is concluded. Outcome summaries of FPPE review reports are also submitted to the Credentials Committee.

Refer also to the FPPE policy MS-02 of The Miriam Hospital Administrative Policy Manual and TJC standard MS08.01.01.

There are occasions during the initial applicant review process that a specific enhanced FPPE program is requested, by either Department or the Credentials Committee. In these situations, the Medical Staff Office, documents the specifics of the FPPE plan, notifies the proctor and the department chief of the details of the FPPE as well as the applicant. The Medical Staff Office then tracks the completion of the specific program and provides reports to the Credentials Committee as requested.

2.2 OPPE

All applicants with privileges, including initial applicants, participate in the Ongoing Professional Practice Evaluation (OPPE) process. Each department, in collaboration with the OpX department, establishes criteria on which to base the OPPE analysis. Data is summarized and reviewed by the Department Chair, or an approved delegated medical staff leader, on a semi-annual basis.

Refer also to the OPPE policy MS-01 of The Miriam Hospital Administrative Policy Manual and TJC standard MS08.01.03.

PART THREE: REAPPOINTMENT PROCEDURES

3.1 Information Collection and Verification

Reappointment applications are distributed 6 months in advance of the appointment cycle expiration date. Applicants are requested to return the reappointment application and supporting documentation approximately 5 months ahead of the cycle end date.

3.1-1 Timeliness of applicant response

Rarely, an applicant will not return an application and supporting documentation in a timely manner, despite repeated notifications and reminders by MSS, and a lapse in privileges occurs (not in relation to an LOA). If the duration of the privileges is 1 day to 6 months after the deadline, the provider will need to complete the reappointment application and pay the initial application fee of \$275.

3.1-2 Types of Information Obtained

The Medical Staff Services Office collects all relevant information regarding the individual's professional and collegial activities, performance and conduct in this Hospital. Such information, which together with the information obtained from the applicant and other external sources shall form the basis for recommendations and action. These shall include, without limitation:

- (a) Clinical performance and patterns of care as demonstrated in the findings of direct observation, quality assessment and improvement, risk management and utilization management activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (where available), provided that other practitioners shall not be identified. This information will include data obtained through the OPPE process over the last 4 semi-annual reporting periods. (Refer also to the OPPE policy MS-01 of The Miriam Hospital Administrative Policy Manual);
- (b) Participation in relevant continuing education activities;
 - (i) Physician applicants for reappointment must submit documentation of at least 40 hours of American Medical Association (AMA) Category I continuing medical education (CME) credits earned during the preceding two years consistent with Rhode Island medical licensure regulations.
 - (ii) All other practitioners will submit documentation of sufficient CME/CEU to meet the requirements promulgated by their corresponding state licensure board averaged over the two-year appointment interval.
- (c) All applicants will have clinical judgment and technical skills assessed. The level/amount of clinical activity (patient care contacts) at the Hospital will be obtained. These data will be obtained by MSS from OpX or from the provider. MSS will ensure appropriate documentation for all criteria based or volume based privileges.
 - (i) Data for applicants in fields performing surgical or other invasive procedures will include the number and types of procedures performed as the surgeon/proceduralist of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes and patient care management and consultations performed.
 - (ii) Data for applicants for reappointment in nonsurgical fields will include the number and types of medical conditions managed/consulted and the procedures performed by the applicant as the responsible practitioner.

- (d) Sanctions imposed or pending
- (e) Attendance at required Medical Staff, Department, Division, and Committee meetings, as specified by Departmental policy;
- (f) Participation as a Medical Staff official, committee member/Chair and proctor, and in on-call coverage roster;
- (g) Timely and accurate completion and preparation of medical records;
- (h) Cooperativeness in working with other practitioners and Hospital personnel;
- (i) General attitude toward patients and the Hospital;
- (j) Peer Reference(s).
- (k) Compliance with all applicable bylaws, policies, rules, and procedures of the Hospital and Medical Staff;
- (l) Any other pertinent information that may be relevant to the Medical Staff member's status and privileges at this Hospital, including the Medical Staff member's activities at other hospitals and medical practice outside the Hospital.

3.1-3 Volume Considerations

Applicants with limited clinical activity at the Hospital are considered to be low volume providers. Consideration of these providers is outlined in Bylaws 3.6.1c.

Courtesy Staff volume exceptions are noted in Section 1.2-1.

3.1-4 Verification of Information

The Medical Staff Services Office personnel will conduct primary source verification of the following items:

- (a) Any professional license
- (b) Board Certification/recertification
- (c) Additional training cited in the reappointment application
- (d) Liability coverage and claims history (with review and signoff by Risk Management if needed)
- (e) Other hospital affiliations

In addition, the National Practitioner Databank will be queried.

3.2 Aging Practitioners

To ensure patient safety and quality of care provided by The Miriam Hospital Medical Staff and APP staff, the capabilities, competencies and health status of each appointee with privileges will be assessed upon reaching the age of seventy (70) and thereafter. For individuals under the age of 70 where appropriate concerns are raised regarding their competency refer to the Physicians Health Committee and the policy on Physicians Health.

At the reappointment date in the year of attaining age seventy (70) and subsequent biannual reappointments, documentation of physical wellness is required as part of the reappointment application. This documentation, along with the quality data related to clinical performance during the prior two-year appointment cycle, will be reviewed with the staff member by the Department Chief as part of the reappointment recommendation evaluation.

- (6) Documentation of a physical examination by a primary care physician within the most recent six month period is submitted by the primary care physician attesting that the staff member does not have an illness or condition that would impair his/her ability to practice medicine.

A personal interview by the Chief of the Department when recommending the physician for reappointment includes clinical performance, health status and consideration of clinical and professional behaviors.

Refer also to the Aging/Senior Physicians' Health policy MS-06 of The Miriam Hospital Administrative Policy Manual.

3.3 Content of Report and Bases for Recommendations and Action

The report of each individual or group required to act on an application must include recommendations for approval, denial, and/or any special limitations on the Medical Staff appointment, staff category, Department and/or Section affiliation, and requested clinical privileges. All documentation and information received by any individual or group during the evaluation process must be included with the application as part of the individual's central credentials file and must be transmitted with the reports and recommendations, as appropriate or requested. The reasons for each recommendation or action to deny, restrict or otherwise limit credentials must be stated, with reference to the completed application and all documentation considered. The report recommendations must be based on the individual's professional qualifications, the individual's ability to deliver quality patient care in an efficient manner, the demonstrated Hospital and community need for the services, the Hospital's capabilities of supporting the requested privileges, and the individual's ability to have qualified coverage of the care requested.

PART FOUR: DELINEATING CLINICAL PRIVILEGES

4.1 Department Responsibility to Define Approach to Delineating Privileges

Each Department must define, in writing, the conditions, operative, invasive and other special procedures that fall within its clinical area, including levels of severity or complexity, age groupings as appropriate, and the requisite training, experience or other qualifications required. These definitions must be incorporated in the processes used for requesting and granting privileges and must be approved by the Credentials Committee, the Medical Executive Committee, and the Board. The scope and processes must be periodically reviewed and revised as necessary to reflect new procedures, instrumentation, treatment modalities and similar advances or changes.

When processes are revised, by additions or deletions or the adoption of new privilege forms, all Medical Staff members holding privileges in the Department must, complete the new forms, request and be processed for privileges added, or comply with the fact that a privilege was deleted.

4.2 Contractual or Employment Relationships

4.2-1 Medical Staff Appointment

A practitioner who is or who will be providing specified professional services pursuant to a contract/employment with the Hospital must meet the same qualifications for appointment to the Medical Staff, must be evaluated for Medical Staff appointment, reappointment and clinical privileges in the same manner, and must fulfill all of the obligations of the medical staff category as any other applicant for Medical Staff appointment.

4.2-2 Effect of Medical Staff Appointment Termination or Clinical Privileges Restriction

Practice at the Hospital is contingent upon continued Medical Staff membership and is also constrained by the extent of clinical privileges granted.

A practitioner's right to use Hospital facilities is therefore automatically terminated when Medical Staff membership expires or is terminated. Similarly, the extent of practice at the Hospital is automatically limited to the extent that clinical privileges are restricted or revoked.

The effect of an adverse change in clinical privileges on continuation of the contract/employment arrangement is governed solely by the terms of the contract/employment arrangement.

4.2-3 Effect of Contract Expiration or Termination

The effect of expiration or other termination of a practitioner's contract/employment agreement upon the practitioner's Medical Staff membership and clinical privileges will be governed solely by the terms of the contract/employment agreement with the Hospital, if it addresses the issue.

If the contract/employment arrangement is silent on the matter, then expiration or other termination of the contract alone will not affect the practitioner's medical staff membership or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which exclusive contractual arrangements have been made.

4.3 Medical Administrative Positions

4.3-1 Medical Staff Appointment

Practitioner(s) engaged by the Hospital in a medical administrative capacity, such as Division Directors, whose professional activities may also include clinical responsibilities such as direct patient care or teaching and/or supervision of patient care activities of other practitioners may need achieve and maintain Medical Staff appointment and clinical privileges appropriate to the clinical responsibilities and discharge Medical Staff obligations appropriate to the granted Medical Staff category and in the same manner applicable to all other Medical Staff members. Refer also Article IV of the Medical Staff Bylaws.

4.3-2 Effect of Medical Staff Appointment Termination or Clinical Privileges Restriction

Adverse revocation of Medical Staff appointment and all clinical privileges precludes continuing in the medical administrative capacity as applicable.

The adverse revocation of select clinical privileges will initiate review of continued medical administrative service.

4.3-3 Effect of Contract Expiration or Termination

Removal or resignation from the medical administrative position alone does not affect the individual's Medical Staff membership or clinical privileges.

PART FIVE: MODIFYING CLINICAL PRACTICE

5.1 Relinquishment of Clinical Privileges

A Medical Staff member or APP who chooses to no longer exercise or to voluntarily restrict or limit the exercise of specific privileges which have previously been granted shall send written notice to the appropriate Department Chair indicating the same and identifying the particular privileges involved and applicable restrictions or limitations. This request for a change in privileges shall be routed for review as outlined in Section 3.3.7 – 3.3.10 of the Bylaws. Documentation of the change of privileges is included in the member's credentials file.

5.2 Increase in Clinical Privileges

A Medical Staff member who wishes to request additional specific privileges which have not previously been granted shall send written notice to the appropriate Department Chair or Medical Staff Office indicating the same and identifying the particular privilege(s) involved. MSS will obtain the following information from the applicant:

1. Letter of Intent (reason for the request)
2. Updated Privilege/Patient Care Services form (if applicable)
3. Supporting Clinical Activity/Patient encounters in support of increase of privileges
4. Updated malpractice insurance certificate (if applicable)
5. Group Coverage List and Verification (if applicable)

A completed change of status packet will be routed for review as outlined in Section 3.3.7 – 3.3.10 of the Bylaws. Documentation of the change of privileges will be included in the member's credentials file.

Once the change of privileges has been approved, the applicant will be notified to complete the FPPE process as outlined in Part II above; and all data systems will be updated as appropriate.

5.3 Modification of Practice Status

A Medical Staff member who plans to make a significant change in his/her practice situation shall send advanced written notice to the appropriate Department Chair or Medical Staff Services indicating the particulars of the change. Examples include leave of absence, resignation, retirement, changes in practice location, changes in practice association, and changes in employment relationship with the hospital. When MSS receives notice of changes in practice status from other sources, changes will be verified with the practitioner prior to documenting the change in status in MSS credentialing database(s).

Depending on the nature of the change, MSS will update appropriate data systems per policy and practice. Resignations, including the reason for the resignation, are documented in the Credentials Committee Report for review by the MEC and BOT.

5.3-1 Leaves of Absence

Circumstances that require notification to MSS include long term sabbatical type leaves and health related leaves that would potentially impact one's ability to provide care in the long term. Short term health related situations, e.g. pregnancy, recovery from a non-debilitating injury, etc, do not require that a formal leave of absence be initiated. Should MSS have questions regarding whether a practitioner needs to be placed on a formal LOA per the bylaws, MSS will contact the appropriate Department Chief and/or CMO for guidance and resolution.

An LOA cannot alter the appointment cycle of the practitioner. MSS will communicate to Chiefs and Practitioners on a LOA that the reappointment process takes 60-90 days to ensure providers understand the timeframe involved in the reappointment process to assist in avoiding lapses in privileges. MSS will also notify the Chief and practitioner that a re-appointment can be processed early to prevent a lapse in privileges.

PART SIX: SPECIAL PRIVILEGING PROCEDURES

6.1 Granting Temporary Privileges

The process for granting temporary privileges is described in the Core Bylaws. MSS facilitates communication between Department Chief, CMO, Medical Staff President, Credentials Committee Chair and Hospital President to document the approval process, and notifies the applicant of the final outcome in writing.

6.2 Procedure for Granting Disaster Privileges

6.2-1 Conditions

In addition to the Bylaws Manual provisions regarding Disaster Privileges, volunteer practitioners will be teamed with Medical Staff members to permit direct observation of care rendered and provide monitoring opportunities and procedural guidance. As circumstances permit or dictate, clinical record reviews will be undertaken to ensure quality of care rendered.

All grants of disaster privileges shall reflect the individual's training and specialty.

PART SEVEN: ADVANCED PRACTICE PROFESSIONALS

7.1 Definition

As defined in Bylaws Article IX, Advanced Practice Professionals (APPs) shall include designated independent and non-independent health care professionals who are qualified by formal training, licensure, and current competence in a health care discipline which the Board of Trustees has approved for practice within the Hospital's scope of services. There are 2 Staff Categories: APP, which is for those practitioners who need privileges at a Lifespan owned and operated facility; and 2) Associate APP, which is for those who do not want privileges to provide care at a Lifespan owned and operated facility, but want/need affiliation with a Lifespan hospital.

7.2 Eligible Practitioners

The specific disciplines include:

- Acupuncturist
- Certified Registered Nurse Anesthetist
- Licensed Independent Clinical Social Worker
- Nurse Practitioner
- Physician Assistant
- Psychiatric Clinical Nurse Specialist
- Radiology Assistant

7.3 Qualifications

A statement of qualifications for each category of APP shall be developed for review by the Credentials Committee, subject to approval by the Board. Each such statement must:

- (a) Be developed with input, from the Chief of the applicable Department(s) or Division(s), and other key stakeholders; and
- (b) Require that the individual APP hold a current license, certificate or such other credential, as may be required by Rhode Island law to exercise the privileges or provide the services being requested; and
- (c) Be delineated on each individual privilege form.

7.4 Prerogatives and Obligations

Prerogatives are listed in the Bylaws.

Each Advanced Practice Professional is obligated to the following:

- (a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate Hospital facilities.
- (b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services and, when necessary and as appropriate to the circumstances of the case, either arrange or alert the principal attending physician of the need for a suitable alternative for such care and supervision.

- (c) Participate when requested in quality review and risk management program activities and in such other functions as may be required from time to time.
- (d) Attend clinical and educational meetings of the Medical Staff and of the Department or Section and any other clinical units with which affiliated.
- (e) May be appointed to serve on Medical Staff Committees and may also be invited to specified Medical Staff meetings, but only at the pleasure of the invitation of the Medical Staff President.
- (f) Abide by the Medical Staff Bylaws and related manuals, the Hospital Bylaws, and all other standards, policies and rules of the Medical Staff and Hospital.
- (g) Prepare and complete in a timely fashion as required in the Medical Staff Rules and Regulations those portions of patients' medical records documenting services provided and any other required records.
- (h) Refrain from any conduct or acts that are or could be reasonably interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

7.5 Scope of Privileges and Service Description

Notwithstanding the apparent scope of practice permitted to any group of Advanced Practice Professional under Rhode Island law or licensure, the scope of privileges and guidelines described above may place limitations on the scope of practice authorized in the Hospital as deemed necessary for the efficient and effective operation of the Hospital or any of its departments or services; for management of personnel, services and equipment; for quality or efficient patient care; or as otherwise deemed by the Board to be in the best interests of patient care in the Hospital.

The scope of practice or granted patient care services available to any group of Advanced Practice Professional shall be developed with input from the appropriate Department Chairs and Section Chiefs, as applicable, and representatives of management. The scope and description of patient care services will be reviewed by the Credentials Committee and recommended for approval to the MEC and BOT. The scope is subject to the approval of the Board.

7.6 Subcategories of Advanced Practice Professionals

As noted in Section 7.1, the Advanced Practice Professionals designation includes designated independent and non-independent health care professionals.

7.6-1 Independent Advanced Practice Professionals

An Independent Advanced Practice Professional is an individual who fulfills the criteria in Bylaws Article IX but is permitted by the Hospital to provide services independently in the Hospital, i.e., without the direction or immediate supervision of a physician, and is not required to have documentation countersigned.

Current policy permits the following types of Advanced Practice Professionals to provide independent services in the Hospital: **Not applicable**

7.6-2 Non-independent Advanced Practice Professionals

A Non-independent Advanced Practice Professional is an individual who is qualified by licensure, certification, or academic and/or clinical training and current competence to function in a medical support role to, and under the direction and supervision of, a practitioner and who is in a health care discipline which the Board has approved to practice in the Hospital.

Current policy permits the following types of Advanced Practice Professionals to provide non-independent services in the Hospital:

- Acupuncturist
- Certified Registered Nurse Anesthetist
- Licensed Independent Clinical Social Worker
- Nurse Practitioner
- Physician Assistant
- Psychiatric Clinical Nurse Specialist
- Radiology Assistant

Continued affiliation as a Non-independent Advanced Practice Professional is contingent upon maintenance of the employment or contractual relationship with the supervising physician. Termination of this relationship will result in an automatic termination of clinical hospital affiliation. Termination of clinical hospital affiliation for this reason does not entitle the APP to procedural rights to due process.

7.7 Terms and Conditions of Affiliation

Each Advanced Practice Professional shall be assigned to a Department(s) and Division(s), if applicable, appropriate to his/her professional training and is subject to an initial Focused Professional Practice Evaluation utilizing metrics defined by the Department/Division.

An Advanced Practice Professional's provision of specified services within any Department or Division is subject to the rules and regulations of that Department and Section and to the authority of the Department or Division Chief, as applicable. The quality and efficiency of the care provided by APPs within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or Hospital quality review, risk management and utilization management mechanisms.

7.8 Appointment and Re-appointment Procedures

APPs will be subject to the same procedures as defined in Parts 1- 6 of this manual.

PART EIGHT: EXPIRING CREDENTIALS

8.1 Process

At the beginning of each month, the Medical Staff Office identifies from the credentialing data base, all providers who have an expiring credential at the end of that month. Notification is sent to the provider via email (and fax) stating:

“Evidence of current credentialing documentation is a requirement for privileges and/or membership at all Lifespan affiliated hospitals. This letter is to inform you that required documentation will be expiring on the date listed. Medical Staff Services must receive a copy of this documentation prior to the expiration date to avoid any disruption to clinical privileges at a Lifespan affiliated hospital.”

Follow-up occurs every two weeks until credential is received. If the credential is not received that information is brought to the attention of the MSS Managers, as well as clinical leadership if necessary, for further action.

8.2 Types of Expiring Credentials by Applicable Staff Category

Expiring Credentials	Staffing Categories Expiring Credentials are Applicable to
Malpractice Insurance	Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Advanced Practice Professionals
Federal DEA Registration	Active, Senior Active, Courtesy, Consulting, Advanced Practice Professionals (NP & PA only)
State Licensure and Substance Control	Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Advanced Practice Professionals
Advanced Practice Certifications	Advanced Practice Professionals
Privileging Criteria Certifications – ACLS, PALS, Neonatal Certification	Active, Senior Active, Courtesy, Consulting, Advanced Practice Professionals who hold privileges requiring certification
Tuberculosis Testing (RIH/TMH)	Active, Senior Active, Courtesy, Consulting, Doctoral, Advanced Practice Professionals

PART NINE: ADOPTION

9.1 This Credentialing Procedures Manual was reviewed and adopted by the TMH Credentials Committee on March 21, 2017

Appendix A

Board Certification and MOC Requirements by Specialty (See attached Excel Document)

Exhibit 44H

CREDENTIALING PROCEDURES MANUAL

Newport Hospital

March 2017

MEDICAL STAFF CREDENTIALING PROCEDURES MANUAL

The framework of the credentialing process is delineated in the Bylaws Manual Articles II, III and IX. The Credentialing Procedures Manual outlines some of the specific administrative details pertinent to the process.

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PART ONE: APPOINTMENT PROCEDURES

1.1 Pre-Application

Prior to releasing an application to any candidate, a pre-application form is sent to the candidate to determine eligibility to the Medical Staff or APP staff by the Medical Staff Office. The following information is solicited:

- a. office and residence address;
- b. staff category and clinical department requested;
- c. extent of anticipated practice at the Hospital;
- d. current/anticipated Medical Staff appointments and hospital affiliations; and
- e. copies of the following documents, as applicable:
 - i. current active, unrestricted license to practice
 - ii. federal Drug Enforcement Agency and Rhode Island controlled substances registration
 - iii. proof of professional liability insurance
 - iv. proof of successful completion of residency training program
 - v. proof of current board certification

Once the Medical Staff Office determines the candidate is eligible for appointment to the Medical Staff, a complete initial application packet is sent to the candidate.

1.2 Application Content

Every applicant must furnish complete information concerning at least the following: Professional school, and postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended, and names of practitioners responsible for monitoring the applicant's performance.

- a. Professional Education and Training Qualifications

Medical Education

An "approved" allopathic medical school is one fully accredited throughout the period of the practitioner's attendance by the Liaison Committee on Medical Education or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

An "approved" osteopathic medical school is one fully accredited throughout the period of the practitioner's attendance by the American Osteopathic Association or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

An "approved" International Medical School is one that is listed in the *World Directory* as meeting eligibility requirements for its students and graduates to apply to ECFMG for ECFMG Certification and examination. The *World Directory* is available at www.wdoms.org. Graduates of these schools must also have a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or, have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Medical Residency Training Programs

An "approved" allopathic or osteopathic residency, or preliminary year of training is one fully accredited during the time of the practitioner's training by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body.

Podiatric Education

An "approved" podiatric medical school is one fully accredited throughout the period of the practitioner's attendance by the Council on Podiatric Medical Education or by a predecessor or successor agency to either of the foregoing or by an equivalent professionally recognized accrediting body. Podiatric medical schools are governed by the American Association of Colleges of Podiatric Medicine (AACPM).

Podiatric Postgraduate Training

An "approved" podiatric residency is one fully accredited by the Council on Podiatric Medical Education during the time of the practitioner's training.

Dental Education

An "approved" school is one fully accredited throughout the period of the practitioner's attendance by the Commission on Dental Accreditation or by a predecessor or successor agency or by an equivalent professionally recognized accrediting body.

Dental Postgraduate Training

An "approved" postgraduate training program is one fully accredited during the time of the practitioner's training by the Commission on Dental Accreditation, or by a predecessor or successor agency or by an equivalent professionally recognized accrediting body.

Psychological Education and Training

A "recognized" graduate program in psychology is one fully accredited during the time of the practitioner's training by the American Psychological Association. A clinical internship in psychology is one accredited by the American Psychological Association. Accredited doctoral programs, internship and post-graduate residencies may be found on the APA Website: http://apps.apa.org/accredsearch/?_ga=1.99974169.669107786.1464380096

- b. All past and all currently valid medical, dental and other professional licensures, permits or certifications, and Federal Drug Enforcement Administration (DEA) and other controlled substances registrations, with the date and number of each.
- c. Specialty or sub-specialty board certification, recertification, or eligibility status to sit for the examination. Each specialty will adhere to the eligibility rules set forth by the respective specialty board.
 - 1) Recognized Boards
 - a) Board Certification for allopathic and osteopathic physicians shall be in accordance with one of the boards recognized by the American Board of Medical Specialties or the American Board of Osteopathic Medicine.
 - b) Board Certification in dentistry shall be in accordance with any Dentistry specialties such as the American Board of Oral and Maxillofacial Surgery, the American Board of Periodontology, or the American Board the Pedodontists.
 - c) Board Certification in podiatric medicine shall be in accordance with one of the following specialty boards recognized by the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery.
 - 2) Board Eligibility - According to the Bylaws, upon appointment to the Medical Staff, a Medical Staff Member who is Board Qualified shall be required to register and take the next

board examination for which he/she is eligible. The duration of process to become Board Certified varies by Board and specialty. See Appendix A for descriptions of the Board Certification processes by Specialty.

- 3) Maintenance of Certification and Recertification – Requirements for maintaining Board Certification, as well as expiration dates for Certification varies by Board and by Specialty. See Appendix A for descriptions of MOC processes.
- d. Health status attestation including substance abuse issues, physical or mental health conditions, and requirements of Rhode Island statutes/regulations regarding healthcare workers.
- 1) Impairment Disclosure
When suspicion or knowledge of an ethical, medical, or behavioral problem is reported, a practitioner may be required to provide such information or to obtain such examination or tests as requested by the Medical Executive Committee. Such examinations shall be performed by a practitioner(s) designated by the Medical Executive Committee.
 - i. Physical or Behavioral Health Impairment: To be free of, or have under adequate control, any physical or behavioral health impairment that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to exercise requested clinical privileges or work cooperatively with others.
 - ii. Substance Abuse Disorder: To be free from abuse of any type of substance that affects cognitive or motor skills or interferes with the ability to exercise requested clinical privileges or work cooperatively with others. A practitioner may be required to submit to on-the-spot testing on the basis of physical manifestations on the job, suspicion based on recent performance, or as follow-up or concurrent monitoring of participation in a treatment program.
- e. Professional liability insurance coverage and information on malpractice claims history and experience (suits and settlements made, concluded and pending), including the names and addresses of present insurance carriers and insurance carrier(s) for the past ten years including Internship, Residency and Fellowship as applicable.
- f. Any pending or completed action involving denial, revocation, suspension, reduction, limitation, or probation of any of the following, and any non-renewal or relinquishment of or withdrawal of an application for any of the following to avoid investigation or possible disciplinary or adverse action.
- 1) License or certificate to practice any profession in any state or country
 - 2) Drug Enforcement Administration or other controlled substances registration
 - 3) Membership or fellowship in local, state or national professional organizations
 - 4) Faculty membership at any medical or other professional school
 - 5) Appointment or employment status, prerogatives or clinical privileges at any other hospital, clinic or health care institution or organization
 - 6) Professional liability insurance
 - 7) Medicare and/or Medicaid participation
- g. Hospital Affiliation and Work/Practice History: Applicants must submit every practice location since graduation from professional/Medical School. Documentation must include location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association in month/year format; names and locations of all other hospitals, clinics or health care institutions or organizations where the applicant provides or provided clinical

services with the inclusive dates of each affiliation in month/year format, status held, and general scope of clinical privileges.

- h. Department/Section assignment, Medical Staff category, and specific clinical privileges requested.
- j. Any current criminal charges pending against the applicant and any past charges including their resolution.
- k. Required peer references.
- l. Evidence of the applicant's agreement with the confidentiality, immunity, and release provisions of the Medical Staff Bylaws and related manuals.
- m. Signed Medical Staff Code of Conduct Attestation Sheet
- n. Other elements required by Hospital or health system policy such as confidentiality statements, HIPAA compliance attestation, and Information System Security items.
 - 1) Criminal Background Check Release Form
 - 2) HIPAA Security Policy (IS 209)
 - 3) Patient Safety Policy
 - 4) HIPAA Privacy Policy Attestation
 - 5) Medicare/CHAMPUS Physician Acknowledgment
 - 6) Lifespan Confidentiality Statement Attestation
 - 7) Corporate Compliance Program Attestation
 - 8) Policy Regarding Interaction with Industry Representatives from the Pharmaceutical, Medical Device and Medical Supply Industries - Attestation
 - 9) EMTALA Policy
- o. Identification verification as referenced by The Joint Commission Standards, MS06.01.03 EP5
- p. Immunization records as mandated by the Rhode Island Department of Health for Healthcare workers.
- q. Documentation of physician coverage for applicants requesting admitting privileges.
- r. Explanation and details on any gaps in excess of thirty days within career progression since graduation from professional/Medical School.
- s. Detailed descriptions of any post-graduate training specialty and/or program changes within the same institution or not.

1.3 Special Considerations – Staff Category

1.3-1 Courtesy Staff

- a) Obligations. Bylaws Section 2.3.4 stipulates that Courtesy Staff members may be required to fulfill one or more of the Active Staff obligations under extraordinary circumstances. If a Department Chair needs to invoke any of these obligations for a Courtesy Staff member(s), he/she shall forward the plan with extenuating circumstances and time frame to the Medical Executive Committee for approval.

In the event that immediate action is necessary, the Officers of the Medical Staff shall review and act upon the Department Chair's plan until the next meeting of the full Medical Executive Committee.

- b) Volume. A Courtesy Staff member will be requested to change his/her staff category to Active and meet all obligations of the Active Staff category if he/she admits or provides services on the average to more than 15 patients in any 12-month period.

The following exceptions to these volume considerations apply (in addition to the coverage stipulation noted in the Bylaws):

1. When it can be demonstrated that the excess volume occurred because of a unique set of circumstances that are unlikely to continue or occur again.
2. For non full-time hospital-based specialists
 - Anesthesiologists
 - Emergency Medicine Physicians
 - Hospitalists
 - Intensivists
 - Pathologists
 - Psychiatrists
 - Radiologists
3. For surgical assistants since they are not primarily responsible for the patient.

1.3-2 Doctoral Staff

Candidates to the Doctoral staff need to be credentialed and privileged if the provider engages in patient interaction that includes treatment protocols and/or uses information for clinical conclusions and care of patients. MSS is advised to seek guidance from the appropriate CMO(s) with questions related to whether a particular candidate should be privileged or not.

1.3-3 Research Scientists

Research Scientists should be credentialed if the research being conducted includes any patient interaction or if the research project comes under the auspices of the IRB (human studies). MSS is advised to seek guidance from the CMOs and Research Administration with questions related to credentialing.

1.4 Application Fees

The hospital Administration, with input and endorsement by the Medical Executive Committee(s) will determine application fees for appointment and reappointment. The fee schedule will be maintained in the Medical Staff Services Office. The application fee must accompany the submitted application and is non-refundable. The application will not be deemed complete until the application fee is received.

1.5 References

The application must include the names of at least three (3) professional references. For applicants in the Associate and Research Scientist categories, one (1) professional reference is required. The named individuals must have equivalent licensure and have had extensive experience in observing and working with the applicant professionally within the past year and can attest to current clinical competency, ethical character, and ability to work cooperatively with others, and who will provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. In most cases, members of the current/potential practice group, training colleagues, the Chief of the RIH or TMH Department to which applicant is applying to or family members and significant others **may NOT** serve as references. At least one reference must practice in the applicant's clinical specialty.

The references will be asked to provide written comments on the following specific areas:

- Medical/Clinical Knowledge
- Technical and Clinical Skills
- Clinical Judgment
- Interpersonal Skills
- Communication Skills
- Professionalism

1.6 Effect of Application

The applicant must sign the application and in so doing:

- a) Attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or termination from the Staff without recourse to the procedural rights;
- b) Agrees to notify the Medical Staff Services Office of any change made or proposed in the status of his/her professional license or permit to practice, Federal DEA or other controlled substances registration, malpractice insurance coverage, membership, employment status or clinical privileges at other institutions/facilities/organizations, and on the status of current or initiation of new malpractice claims;
- c) Agrees to abide by the terms and elements of Bylaws Manual Article III.

1.7 Processing the Application

1.7-1 Applicant's Burden

- a) The applicant has the burden to produce adequate information for a proper evaluation of his/her experience, training, current competence, utilization practice patterns, Continuing Medical Education (CME), and peer references. It is the applicant's responsibility to resolve any doubts about these or any of the qualifications required for Medical Staff appointment or the requested Medical Staff category, Department or Section assignment, or clinical privileges, and to satisfy reasonable requests for information or clarification made by appropriate Staff or Board authorities.
- b) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 90 days after the individual has been notified of the additional information required may be deemed to be withdrawn. If an applicant is responsive to requests from the Medical Staff Office, an application may remain open for up to one (1) year. The individual seeking appointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- c) Personal interviews may be requested by a Department or the Credentials Committee and conducted as appropriate.

1.7-2 Verification of Information

The completed application is submitted to the Medical Staff Services Office and the applicable Department Chairs and Sections Chiefs are notified of its receipt.

The Medical Staff Services Office personnel will conduct primary source verification of the following items:

- a) Any professional license or certification in the state of Rhode Island and any other states where licensure has ever been held
- b) Education including, professional, ECFMG (if applicable)
- c) Training including internship, residency, fellowship (both clinical and research)
- d) Board Certification
- e) Liability coverage and malpractice claims for past 10 years. All found claims, regardless of outcome, will be reviewed by Lifespan's Risk Management Department.
- f) Prior affiliations, work history since graduation of professional/Medical School
- g) Physician/group coverage plan for applicants requesting admitting privileges
- h) Nationwide Criminal Background Screening

Direct submission of written peer references qualifies as primary source verification that can be used when determining current clinical competence. Additional evaluations from external Department Chiefs will be solicited as applicable.

In addition, Medical Staff Services Office personnel will query the National Practitioner Data Bank (NPDB) and OIG and SAM (Excluded Parties List for Medicare/Medicaid).

Applicants will be promptly notified by telephone, mail, or electronic mail of any inconsistencies that arise during the application verification process. If a response has not been received by the tenth day following such notification, a second notification shall be given. This notice will indicate the nature of the additional information the applicant is to provide within a specified time frame. Failure without good cause, to respond in a satisfactory manner by that date may be deemed a voluntary withdrawal of the application.

The list of clinical privileges requested will be sent to all clinical affiliations since graduation to obtain specific information regarding the applicant's experience and competence in exercising each of the privileges requested. Ideally, such verification should address at least the following two specific aspects of current competence:

- (a) For applicants requesting privileges that are surgical or invasive in nature, the number and types of surgical procedures performed as the surgeon of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes. In the case of applicants in nonsurgical fields, the number and types of privileges held to manage the medical conditions by the applicant as the responsible practitioner will be requested. This information may be requested directly from the applicant if not provided by prior facilities.
- (b) The applicant's clinical judgment and technical skills.

Once verification is accomplished, the Medical Staff Services Office will initiate the application review process by informing those involved that the application and all supporting materials are available for review.

1.7-3 Content of Assessments and Bases for Recommendations and Actions

The assessment of each individual or group required to review an application and act on it, must include recommendations for approval, denial, and/or any special limitations on the Medical Staff appointment,

staff category, Department and/or Section affiliation, and requested clinical privileges. All documentation and information received by any individual or group during the evaluation process must be included with the application as part of the individual's central credentials file and must be transmitted with the reports and recommendations, as appropriate or requested. The reasons for each recommendation or action to deny, restrict or otherwise limit credentials must be stated, with reference to the completed application and all documentation considered. The report recommendations must be based on the individual's professional qualifications, the individual's ability to deliver quality patient care in an efficient manner, the demonstrated Hospital and community need for the services, the Hospital's capabilities of supporting the requested privileges, and the individual's ability to have qualified coverage of the care requested.

PART TWO: INDIVIDUALIZED PROFESSIONAL PRACTICE EVALUATION PROCESS

2.1 FPPE

All initial applicants in all staff categories with privileges will undergo a Focused Professional Practice Evaluation (FPPE). Applicants are proctored utilizing one or more of the following as part of the FPPE process:

- Concurrent proctoring: real-time observation of a procedure (*Applicable to: performance of procedures. Minimum Standard: Observation of initial three (3) operative/procedural cases*)
- Retrospective proctoring: review of a case after care has been completed, which may include interviews with personnel involved in the care of the patient.

During the review process of initial applications, the Department Chair, or designee will identify a proctor name and proctoring type, as described above, on the recommendation page in the credentialing packet. Upon Board of Trustee approval to the Medical Staff, the Medical Staff Office communicates directly with the newly appointed member outlining the FPPE policy and process, and provides the appropriate proctoring document(s). The communication states the BOT approval date and that the first cases at the facility should be proctored. It is the applicant's responsibility to coordinate with the proctor to have the proctoring forms completed. The completed forms are then returned to the Medical Staff Office. Once completed proctoring forms are returned, a FPPE review packet is prepared for the department chief which include the completed proctoring forms. After Department Chair approval, successful completion of the FPPE is documented in the Medical Staff credentialing software, and the member is notified when the FPPE period is concluded. Outcome summaries of FPPE review reports are also submitted to the Credentials Committee.

Refer also to the FPPE policy #4133 of the Newport Hospital Administrative Policy Manual and TJC standard MS08.01.01.

There are occasions during the initial applicant review process that a specific enhanced FPPE program is requested, by either Department or the Credentials Committee. In these situations, the Medical Staff Office, documents the specifics of the FPPE plan, notifies the proctor and the department chief of the details of the FPPE as well as the applicant. The Medical Staff Office then tracks the completion of the specific program and provides reports to the Credentials Committee as requested.

2.2 OPPE

All applicants with privileges, including initial applicants, participate in the Ongoing Professional Practice Evaluation (OPPE) process. Each department, in collaboration with the OpX department, establishes criteria on which to base the OPPE analysis. Data is summarized and reviewed by the Department Chair, or an approved delegated medical staff leader, on a semi-annual basis.

Refer also to the OPPE policy #4132 of the Newport Hospital Administrative Policy Manual and TJC standard MS08.01.03.

PART THREE: REAPPOINTMENT PROCEDURES

3.1 Information Collection and Verification

Reappointment applications are distributed 6 months in advance of the appointment cycle expiration date. Applicants are requested to return the reappointment application and supporting documentation approximately 5 months ahead of the cycle end date.

3.1-1 Timeliness of applicant response

Rarely, an applicant will not return an application and supporting documentation in a timely manner, despite repeated notifications and reminders by MSS, and a lapse in privileges occurs (not in relation to an LOA). If the duration of the privileges is 1 day to 6 months after the deadline, the provider will need to complete the reappointment application and pay the initial application fee of \$275.

3.1-2 Types of Information Obtained

The Medical Staff Services Office collects all relevant information regarding the individual's professional and collegial activities, performance and conduct in this Hospital. Such information, which together with the information obtained from the applicant and other external sources shall form the basis for recommendations and action. These shall include, without limitation:

- (a) Clinical performance and patterns of care as demonstrated in the findings of direct observation, quality assessment and improvement, risk management and utilization management activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (where available), provided that other practitioners shall not be identified. This information will include data obtained through the OPPE process over the last 4 semi-annual reporting periods. (Refer also to the OPPE policy #4132 of the Newport Hospital Administrative Policy Manual);
- (b) Participation in relevant continuing education activities;
 - (i) Physician applicants for reappointment must submit documentation of at least 40 hours of American Medical Association (AMA) Category I continuing medical education (CME) credits earned during the preceding two years consistent with Rhode Island medical licensure regulations.
 - (ii) All other practitioners will submit documentation of sufficient CME/CEU to meet the requirements promulgated by their corresponding state licensure board averaged over the two-year appointment interval.
- (c) All applicants will have clinical judgment and technical skills assessed. The level/amount of clinical activity (patient care contacts) at the Hospital will be obtained. These data will be obtained by MSS from OpX or from the provider. MSS will ensure appropriate documentation for all criteria based or volume based privileges.
 - (i) Data for applicants in fields performing surgical or other invasive procedures will include the number and types of procedures performed as the surgeon/proceduralist of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes and patient care management and consultations performed.
 - (ii) Data for applicants for reappointment in nonsurgical fields will include the number and types of medical conditions managed/consulted and the procedures performed by the applicant as the responsible practitioner.

- (d) Sanctions imposed or pending
- (e) Attendance at required Medical Staff, Department, Section, and Committee meetings, as specified by Departmental policy;
- (f) Participation as a Medical Staff official, committee member/Chair and proctor, and in on-call coverage roster;
- (g) Timely and accurate completion and preparation of medical records;
- (h) Cooperativeness in working with other practitioners and Hospital personnel;
- (i) General attitude toward patients and the Hospital;
- (j) Peer Reference(s).
- (k) Compliance with all applicable bylaws, policies, rules, and procedures of the Hospital and Medical Staff;
- (l) Any other pertinent information that may be relevant to the Medical Staff member's status and privileges at this Hospital, including the Medical Staff member's activities at other hospitals and medical practice outside the Hospital.

3.1-3 Volume Considerations

Applicants with limited clinical activity at the Hospital are considered to be low volume providers. Consideration of these providers is outlined in Bylaws 3.6.1c.

Courtesy Staff volume exceptions are noted in Section 1.2-1.

3.1-4 Verification of Information

The Medical Staff Services Office personnel will conduct primary source verification of the following items:

- (a) Any professional license
- (b) Board Certification/recertification
- (c) Additional training cited in the reappointment application
- (d) Liability coverage and claims history (with review and signoff by Risk Management if needed)
- (e) Other hospital affiliations

In addition, the National Practitioner Databank will be queried.

3.2 Aging Practitioners

Upon reappointment for all credentialed providers who have reached the age of 70, and upon each subsequent reappointment, a focused professional performance evaluation will be initiated that mirrors the corresponding department's Provisional Review criteria with the addition of direct observation of representative categories of invasive procedures or other specific skill sets as deemed necessary by the Department Chair.

The required focused professional performance review will be included as a stipulation of the practitioner's reappointment and will be coordinated by the Department Chair, the Medical Staff Services Office, and the Performance Evaluation and Improvement Department.

Identification and use of a proctor, especially related to invasive procedures, is the practitioner's responsibility with the Department Chair's approval.

3.3 Content of Report and Bases for Recommendations and Action

The report of each individual or group required to act on an application must include recommendations for approval, denial, and/or any special limitations on the Medical Staff appointment, staff category, Department and/or Section affiliation, and requested clinical privileges. All documentation and information received by any individual or group during the evaluation process must be included with the application as part of the individual's central credentials file and must be transmitted with the reports and recommendations, as appropriate or requested. The reasons for each recommendation or action to deny, restrict or otherwise limit credentials must be stated, with reference to the completed application and all documentation considered. The report recommendations must be based on the individual's professional qualifications, the individual's ability to deliver quality patient care in an efficient manner, the demonstrated Hospital and community need for the services, the Hospital's capabilities of supporting the requested privileges, and the individual's ability to have qualified coverage of the care requested.

PART FOUR: DELINEATING CLINICAL PRIVILEGES

4.1 Department Responsibility to Define Approach to Delineating Privileges

Each Department must define, in writing, the conditions, operative, invasive and other special procedures that fall within its clinical area, including levels of severity or complexity, age groupings as appropriate, and the requisite training, experience or other qualifications required. These definitions must be incorporated in the processes used for requesting and granting privileges and must be approved by the Credentials Committee, the Medical Executive Committee, and the Board. The scope and processes must be periodically reviewed and revised as necessary to reflect new procedures, instrumentation, treatment modalities and similar advances or changes.

When processes are revised, by additions or deletions or the adoption of new privilege forms, all Medical Staff members holding privileges in the Department must, complete the new forms, request and be processed for privileges added, or comply with the fact that a privilege was deleted.

4.2 Contractual or Employment Relationships

4.2-1 Medical Staff Appointment

A practitioner who is or who will be providing specified professional services pursuant to a contract/employment with the Hospital must meet the same qualifications for appointment to the Medical Staff, must be evaluated for Medical Staff appointment, reappointment and clinical privileges in the same manner, and must fulfill all of the obligations of the medical staff category as any other applicant for Medical Staff appointment.

4.2-2 Effect of Medical Staff Appointment Termination or Clinical Privileges Restriction

Practice at the Hospital is contingent upon continued Medical Staff membership and is also constrained by the extent of clinical privileges granted.

A practitioner's right to use Hospital facilities is therefore automatically terminated when Medical Staff membership expires or is terminated. Similarly, the extent of practice at the Hospital is automatically limited to the extent that clinical privileges are restricted or revoked.

The effect of an adverse change in clinical privileges on continuation of the contract/employment arrangement is governed solely by the terms of the contract/employment arrangement.

4.2-3 Effect of Contract Expiration or Termination

The effect of expiration or other termination of a practitioner's contract/employment agreement upon the practitioner's Medical Staff membership and clinical privileges will be governed solely by the terms of the contract/employment agreement with the Hospital, if it addresses the issue.

If the contract/employment arrangement is silent on the matter, then expiration or other termination of the contract alone will not affect the practitioner's medical staff membership or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which exclusive contractual arrangements have been made.

4.3 **Medical Administrative Positions**

4.3-1 **Medical Staff Appointment**

Practitioner(s) engaged by the Hospital in a medical administrative capacity, such as the Vice President of Medical Affairs, whose professional activities may also include clinical responsibilities such as direct patient care or teaching and/or supervision of patient care activities of other practitioners must achieve and maintain Medical Staff appointment and clinical privileges appropriate to the clinical responsibilities and discharge Medical Staff obligations appropriate to the granted Medical Staff category and in the same manner applicable to all other Medical Staff members.

4.3-2 **Effect of Medical Staff Appointment Termination or Clinical Privileges Restriction**

Adverse revocation of Medical Staff appointment and all clinical privileges precludes continuing in the medical administrative capacity.

The adverse revocation of select clinical privileges will initiate Board review of continued medical administrative service.

4.3-3 **Effect of Contract Expiration or Termination**

Removal or resignation from the medical administrative position alone does not affect the individual's Medical Staff membership or clinical privileges.

PART FIVE: MODIFYING CLINICAL PRACTICE

5.1 Relinquishment of Clinical Privileges

A Medical Staff member or APP who chooses to no longer exercise or to voluntarily restrict or limit the exercise of specific privileges which have previously been granted shall send written notice to the appropriate Department Chair indicating the same and identifying the particular privileges involved and applicable restrictions or limitations. This request for a change in privileges shall be routed for review as outlined in Section 3.3.7 – 3.3.10 of the Bylaws. Documentation of the change of privileges is included in the member's credentials file.

5.2 Increase in Clinical Privileges

A Medical Staff member who wishes to request additional specific privileges which have not previously been granted shall send written notice to the appropriate Department Chair or Medical Staff Office indicating the same and identifying the particular privilege(s) involved. MSS will obtain the following information from the applicant:

1. Letter of Intent (reason for the request)
2. Updated Privilege/Patient Care Services form (if applicable)
3. Supporting Clinical Activity/Patient encounters in support of increase of privileges
4. Updated malpractice insurance certificate (if applicable)
5. Group Coverage List and Verification (if applicable)

A completed change of status packet will be routed for review as outlined in Section 3.3.7 – 3.3.10 of the Bylaws. Documentation of the change of privileges will be included in the member's credentials file.

Once the change of privileges has been approved, the applicant will be notified to complete the FPPE process as outlined in Part II above; and all data systems will be updated as appropriate.

5.3 Modification of Practice Status

A Medical Staff member who plans to make a significant change in his/her practice situation shall send advanced written notice to the appropriate Department Chair or Medical Staff Services indicating the particulars of the change. Examples include leave of absence, resignation, retirement, changes in practice location, changes in practice association, changes in employment relationship with the hospital or contractors, and changes from military to civilian practice. When MSS receives notice of changes in practice status from other sources, changes will be verified with the practitioner prior to documenting the change in status in MSS credentialing database(s).

Depending on the nature of the change, MSS will update appropriate data systems per policy and practice. Resignations, including the reason for the resignation, are documented in the Credentials Committee Report for review by the MEC and BOT.

5.3-1 Leaves of Absence

Circumstances that require notification to MSS include long term sabbatical type leaves and health related leaves that would potentially impact one's ability to provide care in the long term. Short term health related situations, e.g. pregnancy, recovery from a non-debilitating injury, etc, do not require that a formal leave of absence be initiated. Should MSS have questions regarding whether a practitioner needs to be placed on a formal LOA per the bylaws, MSS will contact the appropriate Department Chief and/or CMO for guidance and resolution.

An LOA cannot alter the appointment cycle of the practitioner. MSS will communicate to Chiefs and Practitioners on a LOA that the reappointment process takes 60-90 days to ensure providers understand the timeframe involved in the reappointment process to assist in avoiding lapses in privileges. MSS will also notify the Chief and practitioner that a re-appointment can be processed early to prevent a lapse in privileges.

PART SIX: SPECIAL PRIVILEGING PROCEDURES

6.1 Granting Temporary Privileges

The process for granting temporary privileges is described in the Core Bylaws. MSS facilitates communication between Department Chief, CMO, Medical Staff President, Credentials Committee Chair and Hospital President to document the approval process, and notifies the applicant of the final outcome in writing.

6.1-2 Department of Defense

For a Department of Defense practitioner who has been assigned to Naval Health Clinic New England and is requesting clinical privileges at Newport Hospital in accordance with the External Partnership Agreement between Newport Hospital and Naval Health Clinic New England, receipt of a Navy Interfacility Credentials Transfer Brief (ICTB), which has been signed by the Commanding Officer, or designee, Naval Health Clinic New England will satisfy the above licensure and reference requirements. Such ICTB shall contain documentation that the following have been verified at the primary source by the Department of Defense:

- a) Completion of professional school, degree, internships, residency, and fellowships;
- b) Expiration dates of current state licensures and certifications;
- c) Expiration date of specialty board certifications and/or recertifications;
- d) Contingency training in basic life support, advanced cardiac life support, advanced trauma life support, and pediatric and/or neonatal advanced life support as applicable;
- e) A list of current Naval Health Clinic New England staff privileges; and
- f) A list of requested clinical privileges at Newport Hospital if different from (5) above; and
- g) A statement indicating whether the practitioner applying for temporary privileges is under investigation.

6.2 Procedure for Granting Disaster Privileges

6.2-1 Conditions

In addition to the Bylaws Manual provisions regarding Disaster Privileges, volunteer practitioners will be teamed with Medical Staff members to permit direct observation of care rendered and provide monitoring opportunities and procedural guidance. As circumstances permit or dictate, clinical record reviews will be undertaken to ensure quality of care rendered.

All grants of disaster privileges shall reflect the individual's training and specialty.

PART SEVEN: ADVANCED PRACTICE PROFESSIONALS

7.1 Definition

As defined in Bylaws Article IX, Advanced Practice Professionals (APPs) shall include designated independent and non-independent health care professionals who are qualified by formal training, licensure, and current competence in a health care discipline which the Board of Trustees has approved for practice within the Hospital's scope of services. There are 2 Staff Categories: APP, which is for those practitioners who need privileges at a Lifespan facility; and 2) Associate APP, which is for those who do not want privileges to provide care at a Lifespan facility, but want/need an affiliation with a Lifespan facility.

7.2 Eligible Practitioners

The specific disciplines approved by the Board include:

- Acupuncturist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Nurse Practitioner
- Physician Assistant
- Masters Level psychologist or other clinician who meets the criteria as established by the RI Mental Health Law
- LICSW
- Psychiatric Nurse Clinician

7.3 Qualifications

A statement of qualifications for each category of APP shall be developed for review by the Credentials Committee form, subject to approval by the Board. Each such statement must:

- (a) Be developed with input, from the Chair of the applicable Department(s) or Chief of the applicable Section(s), from the physician supervisor of the APP, and from other representatives of the Medical Staff, management, and the Hospital's other professional staff; and
- (b) Require that the individual APP hold a current license, certificate or such other credential, as may be required by Rhode Island law to exercise the privileges or provide the services being requested; and
- (c) Be delineated on each individual privilege form.

7.4 Prerogatives and Obligations

Prerogatives are listed in the Bylaws.

Each Advanced Practice Professional is obligated to the following:

- (a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate Hospital facilities.
- (b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services and, when

necessary and as appropriate to the circumstances of the case, either arrange or alert the principal attending physician of the need for a suitable alternative for such care and supervision.

- (c) Participate when requested in quality review and risk management program activities and in such other functions as may be required from time to time.
- (d) Attend clinical and educational meetings of the Medical Staff and of the Department or Section and any other clinical units with which affiliated.
- (e) May be appointed to serve on Medical Staff Committees and may also be invited to specified Medical Staff meetings, but only at the pleasure of the invitation of the Medical Staff President.
- (f) Abide by the Medical Staff Bylaws and related manuals, the Hospital Bylaws, and all other standards, policies and rules of the Medical Staff and Hospital.
- (g) Prepare and complete in a timely fashion as required in the Medical Staff Rules and Regulations those portions of patients' medical records documenting services provided and any other required records.
- (h) Refrain from any conduct or acts that are or could be reasonably interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

7.5 Scope of Privileges and Service Description

Notwithstanding the apparent scope of practice permitted to any group of Advanced Practice Professional under Rhode Island law or licensure, the scope of privileges and guidelines described above may place limitations on the scope of practice authorized in the Hospital as deemed necessary for the efficient and effective operation of the Hospital or any of its departments or services; for management of personnel, services and equipment; for quality or efficient patient care; or as otherwise deemed by the Board to be in the best interests of patient care in the Hospital.

The scope of practice or granted patient care services available to any group of Advanced Practice Professional shall be developed with input from the appropriate Department Chairs and Section Chiefs, as applicable, and representatives of management. The scope and description of patient care services will be reviewed by the Credentials Committee and recommended for approval to the MEC and BOT. The scope is subject to the approval of the Board.

7.6 Subcategories of Advanced Practice Professionals

As noted in Section 7.1, the Advanced Practice Professionals designation includes designated independent and non-independent health care professionals.

7.6-1 Independent Advanced Practice Professionals

An Independent Advanced Practice Professional is an individual who fulfills the criteria in Bylaws Article IX but is permitted by the Hospital to provide services independently in the Hospital, i.e., without the direction or immediate supervision of a physician, and is not required to have documentation countersigned.

Current policy of the Board of Trustees permits the following types of Advanced Practice Professionals to provide independent services in the Hospital:

1. Nurse Practitioners
2. Nurse Midwives

7.6-2 Non-independent Advanced Practice Professionals

A Non-independent Advanced Practice Professional is an individual who is qualified by licensure, certification, or academic and/or clinical training and current competence to function in a medical support role to, and under the direction and supervision of, a practitioner and who is in a health care discipline which the Board has approved to practice in the Hospital.

Current policy of the Board of Trustees permits the following types of Advanced Practice Professionals to provide non-independent services in the Hospital:

1. Physician Assistants
2. Certified Registered Nurse Anesthetists
3. Qualified Mental Health Professionals assigned to one of the State of Rhode Island Community Mental Health Centers.

Continued affiliation as a Non-independent Advanced Practice Professional is contingent upon maintenance of the employment or contractual relationship with the supervising physician or Medical Director. Termination of this relationship will result in an automatic termination of clinical hospital affiliation. Termination of clinical hospital affiliation for this reason does not entitle the APP to procedural rights to due process.

7.7 Terms and Conditions of Affiliation

Each Advanced Practice Professional shall be assigned to a Department(s) and Section, if applicable, appropriate to his/her professional training and is subject to an initial Focused Professional Practice Evaluation utilizing metrics defined by the Department/Section.

An Advanced Practice Professional's provision of specified services within any Department or Section is subject to the rules and regulations of that Department and Section and to the authority of the Department Chair or Section Chief, as applicable. The quality and efficiency of the care provided by APPs within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or Hospital quality review, risk management and utilization management mechanisms.

7.8 Appointment and Re-appointment Procedures

APPs will be subject to the same procedures as defined in Parts 1- 6 of this manual.

PART VIII: EXPIRING CREDENTIALS**8.1 Process**

At the beginning of each month, Medical Staff Services identifies from the credentialing data base, all providers who have an expiring credential at the end of that month. Notification is sent to the provider via email (and fax) stating:

“Evidence of current credentialing documentation is a requirement for privileges and/or membership at all Lifespan affiliated hospitals. This letter is to inform you that required documentation will be expiring on the date listed. Medical Staff Services must receive a copy of this documentation prior to the expiration date to avoid any disruption to clinical privileges at a Lifespan affiliated hospital.”

Follow-up occurs every two weeks until credential is received. If the credential is not received that information is brought to the attention of the MSS Managers and clinical leadership if necessary, for further action.

8.2 Types of Expiring Credentials by Applicable Staff Category

Expiring Credentials	Staffing Categories Expiring Credentials are Applicable to
Malpractice Insurance	Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Advanced Practice Professionals
Federal DEA Registration	Active, Senior Active, Courtesy, Consulting, Advanced Practice Professionals (NP & PA only)
State Licensure and Substance Control	Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Advanced Practice Professionals
Advanced Practice Certifications	Advanced Practice Professionals
Privileging Criteria Certifications – ACLS, PALS, Neonatal Certification	Active, Senior Active, Courtesy, Consulting, Advanced Practice Professionals who hold privileges requiring certification
Tuberculosis Testing (RIH/TMH)	Active, Senior Active, Courtesy, Consulting, Doctoral, Advanced Practice Professionals

PART NINE: ADOPTION

9.1 Credentials Committee

This Credentialing Procedures Manual was reviewed and adopted by the Credentials Committee on March 21, 2017.

Appendix A

Board Certification and MOC Requirements by Specialty