NEWPORT HOSPITAL
Newport, Rhode Island 02840-2299

CREDENTIALING PROCEDURES MANUAL

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MEDICAL STAFF CREDENTIALING PROCEDURES MANUAL
NEWPORT HOSPITAL
Newport, Rhode Island

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DEFINITIONS

The following definitions, as stated in the Medical Staff Bylaws, apply to the provisions of this Credentialing Procedures Manual. The definitions are presented in alphabetical order.

1. Allied Health Professional (AHP) is an individual who is qualified by academic and/or clinical training and by prior and continuing experience 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. Allied Health Professionals are not considered members of the Medical Staff.

2. Board of Trustees (BOT) is the governing body of the Hospital, the Board of Trustees of Newport Hospital. As appropriate to the context and consistent with the Bylaws of the Hospital and delegations of authority made by the Board, it may also mean any committee of the Board or any individual authorized by the Board to act on its behalf on certain matters.

3. Chief Executive Officer (CEO) -- See definition 16.

4. Clinical Privileges or Privileges are the permission granted by the Board to a practitioner to provide those diagnostic, therapeutic, medical, dental, or surgical services specifically delineated to him.

5. Dentist is an individual with a DDS degree, or its equivalent, who is fully licensed to practice dentistry.

6. Ex Officio is service as a member of a body by virtue of office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.

7. Hospital is Newport Hospital of Newport, Rhode Island.

8. JCAHO is the Joint Commission on Accreditation for Healthcare Organizations.

9. Licensed Independent Practitioner (LIP) is any individual permitted by law and by the organization to provide care, treatment, and services, w/o direction or supervision.

10. Medical Staff or Staff is the organizational component of the Hospital that includes all practitioners as defined below who are appointed to membership on it and are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

11. Medical Staff and Board authorities or authorities of the Medical Staff and Board are committees, officers, Departments, Sections and any other clinical units of the Staff, and the Board and any committees or officers thereof, who have defined responsibilities in effecting the particular function or activity that is the subject of the particular provision in which the defined phrase is used.

12. Medical Staff member in good standing or member in good standing is a practitioner who has been appointed to the Medical Staff or to a particular category of the Staff, as the context requires, and who is not under either a full appointment suspension or a full or partial suspension of voting, office-holding or other prerogatives imposed by operation of any section of these Bylaws and the related manuals or any other policies of the Medical Staff or the Hospital.

13. Medical Staff Bylaws and related manuals or Bylaws are any one or more the following documents as appropriate to the context:

- Bylaws of the Medical Staff
- Medical Staff Credentialing Procedures Manual
- Medical Staff Fair Hearing Plan
- Medical Staff Organization Manual
- General Rules and Regulations of the Medical Staff

14. Medical Staff Year is the 12-month period commencing on January 1 of each year and ending on December 31 of the same year.

15. Physician is an individual with a M.D. or D.O. degree, who is fully licensed to practice medicine.

16. Practitioner unless otherwise expressly provided, is any physician, dentist, or oral surgeon who either: (a) is applying for appointment to the Medical Staff and for clinical privileges; or (b) currently holds appointment to the Medical Staff and exercises specific delineated clinical privileges; or (c) is applying for or is exercising temporary privileges pursuant to Section 5.7 of the Medical Staff Bylaws.

17. Prerogative is a participatory right granted, by virtue of Staff category or otherwise, to a Staff member, Staff Affiliate, or Allied Health Professional, and exercisable subject to the ultimate authority of the Board of Trustees and to the conditions and limitations imposed in the Medical Staff Bylaws and related manuals and in other Hospital and Medical Staff policies.

18. President/Chief Executive Officer (CEO) is the individual appointed by the Board of Trustees as the chief executive office of the Hospital to manage the affairs of the Hospital. The CEO may, consistent with his responsibilities under the Bylaws of the Hospital, designate a representative to perform his responsibilities under the Medical Staff Bylaws and related manuals.

19. Special Notice is written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgement of receipt.

20. Staff Affiliate is an individual who is qualified by formal training, prior and continuing experience and current competence in a health care discipline which the Board has determined to allow to practice in the Hospital and who is licensed by the State and permitted by the Hospital to provide services independently in the Hospital, i.e., without the direction or immediate supervision of a physician. Staff Affiliates are not considered members of the Medical Staff.

21. Teleservices Group is a grouping of individuals who provide telemedicine related services for which Newport Hospital performs partial or complete privileging action. The privilege process is under the hospital's purview and responsibility but the individuals are not appointed as members of the Medical Staff.

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Amended
10/15/1999
05/10/2000
09/12/2001
04/21/2005
06/08/2005

PART ONE: APPOINTMENT PROCEDURES

1.1 Pre-application

A request for an application to the Medical Staff of Newport Hospital must be submitted to the Medical Staff Services Office.

A pre-application form may be forwarded to the practitioner requesting at least the following information to determine eligibility for staff application:

(a) Office and residence address

(b) Category and clinical department requested

(c) Extent to which practitioner anticipates using Newport Hospital

(d) Current/anticipated medical staff appointments

(e) Copies of the following documents:

- Current and unconditional license of practice in Rhode Island
- DEA and RI controlled substances registration (if applicable)
- Professional liability insurance ($1,000,000/3,000,000)
- Proof of successful completion of residency training program
- Proof of board certification, if applicable

If the pre-applicant meets credentialing criteria and offers services within the hospital scope of practice, an application form will be forwarded.

1.2 Application

An application for Staff appointment must be submitted by the applicant in writing and on the Hospital-approved form. Prior to the application being submitted, the applicant will be provided access to a copy of the Hospital Bylaws, the Medical Staff Bylaws and related manuals, the rules and regulations of applicable Departments, and other Hospital and Medical Staff policies and resolutions relating to clinical practice in the Hospital.

Current government issued/sanctioned photographic identification must accompany the application. Examples of the types of identification that may be used include:

- United States Passport
- Foreign Passport with Employment Authorization
- Driver's License or State ID
- U.S. Military ID

1.3 Application Content

Every application must furnish complete information concerning at least the following:

(a) Undergraduate, 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.

(b) All past and all currently valid medical, dental and other professional licensures, permits or certifications, and Drug Enforcement Administration (DEA) and other controlled substances registrations, with the date and number of each. A copy of the current Rhode Island license and DEA and Rhode Island controlled substances certificates must accompany the application.

(c) Specialty or sub-specialty board certification, recertification, or eligibility status to sit for the examination.

(d) Health status including substance abuse issues, physical or mental health conditions, and requirements of Rhode Island statutes/regulations regarding healthcare workers.

(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 and past insurance carriers.

(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) Location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; 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, status held, and general scope of clinical privileges.

(h) Department/Section assignment, Staff category, and specific clinical privileges requested.

Amended 06/14/2006

(i) Any current criminal charges pending against the applicant and any past charges including their resolution.

(j) References as required by Section 1.4 below.

(k) Evidence of the applicant's agreement with the confidentiality, immunity, and release provisions of the Medical Staff Bylaws and this Credentialing Procedures Manual.

Amended 03/11/2009

(l) Signed Medical Staff Code of Conduct Attestation Sheet

(m)Other elements required by Hospital or Lifespan policy such as HIPAA and Information System Security items.

1.3-1 Application Fees

The 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 written application and is non-refundable. The application will not be processed until the application fee is received.

1.4 References

The application must include the names of at least three (3) professional references not newly associated or about to become partners with the applicant in professional practice or personally related to him/her, who have personal knowledge of the applicant's current clinical ability, 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.

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The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time. At least one must be from a peer in the applicant's specialty and licensure who ideally is not formerly, currently or about to become associated with him/her in practice.

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

1.5 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 for summary dismissal from the Staff without recourse to the procedural rights provided in the Fair Hearing Plan;

(b) Signifies his/her willingness to appear for interviews in connection with his/her application;

(c) Agrees to abide by the terms of the Bylaws and related manuals and policy manuals of the Medical Staff and those of the Hospital if granted membership and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment and/or privileges are granted;

(d) Agrees to maintain an ethical practice and to provide continuous care to his/her patients;

(e) Agrees to notify the Medical Staff President and the CEO of any change made or proposed in the status of his/her professional license or permit to practice, 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;

(f) Authorizes and consents to Hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence;

(g) Releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the applicant's background, experience, clinical competence, professional ethics, utilization practice patterns, character, and other qualifications for Staff appointment and clinical privileges.

For purposes of this Section, the term "Hospital representative" is defined in Section 12.1 of the Medical Staff Bylaws.

1.6 Processing the Application

1.6-1 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 ability to work cooperatively with others. It is the applicant’s responsibility to resolve any doubts about these or any of the qualifications required for Staff appointment or the requested 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 60 days after the individual has been notified of the additional information required shall be deemed to be withdrawn. The individual seeking appointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(c) When the file is complete, the applicant will be notified to schedule an interview with the appropriate Department Chair and/or Section Chief. The interview process shall be concluded within 90 days of the date that the applicant receives notification. Failure to hold the interview within the specified time period without good cause shall be deemed a voluntary withdrawal of the application.

1.6-2 Verification of Information

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

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

(a) Any professional license or certification
(b) Education including undergraduate, professional, ECFMG (if applicable)
(c) Training including internship, residency, fellowship
(d) Board Certification
(e) Liability coverage and claims

Direct submission of written peer references qualifies as primary source verification that can be used when determining current clinical competence.

In addition, Medical Staff Office personnel will query the National Practitioner Data Bank (NPDB).

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 is deemed a voluntary withdrawal of the application.

The list of clinical privileges requested will be sent to all clinical affiliations dating back at least 10 years 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 Office will forward the application and all supporting materials to the chair of each department in which the applicant seeks privileges.

1.6-3 Content of Report and Bases for Recommendations and Actions

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 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. Any dissenting views

from the majority position at any point in the process must be documented in a minority report which states the reason for the differing view, the information on which it is based, and the alternative recommendations, if any. Any minority report must be transmitted with the majority report.

1.6-4 Time Periods for Processing

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

Individual/Group	Time
(a) Medical Staff Office	75 days
(b) Section Chief/Dept.	30 days (combined time) after receiving material from Medical Staff Office
(c) Cred. Com.	30 days after receiving reports from (b)
(d) MEC	Next regular meeting after receiving report from (c
(e) Board of Trustees	Next regular meeting after receiving report, if any, from d)

These time periods are suggested guidelines and are not directives such as to create any rights for a practitioner to have an application processed within these precise periods. If the provisions of the Fair Hearing Plan are activated, the time requirements provided there govern the continued processing of the application. If action does not occur at a particular step in the process and the delay is without apparent cause, the next higher authority may immediately proceed to consider the application and all of the supporting information or may be directed to proceed by the President of the Medical Staff on behalf of the MEC or by the CEO on behalf of the Board.

1.6-5 Department and Section Evaluation

The chair of each department in which the applicant seeks privileges, shall review the application and its supporting documentation and forward to the Credentials Committee a written report as required by Section 1.6-3. Where applicable, the chief of each section in which the applicant seeks privileges will prepare a similar report and will forward it to the Department Chair and the Credentials Committee. All information sought or acquired by a Chair or Chief of a Department, Section, or Committee as part of this evaluation must be included with these reports.

The Department Chair and/or Section Chief, or their respective designees, shall interview the applicant. Such interview shall include, at a minimum, a detailed verbal description by the applicant of his/her training and experience and specific review of the clinical privileges being requested as they relate to that training and experience. If concerns arise during the interview process, a second interview will be conducted by a member of the Credentials Committee or the Vice President of Medical Affairs (VPMA) to clarify the concerns.

If a Department Chair or Section Chief deems it necessary to obtain further information, the report may be deferred up to 45 days. In such a case, the applicant will be notified of the delay and the reasons for the delay by the Department Chair via the Medical Staff Office. The Credentials Committee and Medical Staff President will also be notified of the delay in these proceedings. If the applicant is asked to provide additional information or a specific release/ authorization to allow Hospital representatives to obtain information, the notice to him/her must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure to respond in a satisfactory manner by that date without good cause is deemed a voluntary withdrawal of the application.

1.6-6 Credentials Committee Evaluation

The Credentials Committee shall review the application, the supporting documentation, and the reports from the Department Chairs, Section Chiefs, and all other relevant information. In addition to the provisions in 1.6-5 above, the Credentials Committee may, at its discretion, designate one or more of its members to conduct an interview with the applicant. If the Credentials Committee requires further information, it may defer submitting its report but generally for not more than 45 days, except for good cause, and must notify the applicant and the President of the Staff in writing of the deferral and the grounds. If the applicant is to provide the additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him/her must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure, to respond in a satisfactory manner by that date without good cause is deemed a voluntary withdrawal of the application.

The Credentials Committee shall prepare its written report and recommendations as required by Section 1.6-3 and forward it to the Medical Executive Committee.

1.6-7 Medical Executive Committee Action

The Medical Executive Committee (MEC) will review the Credentials Committee report as well as the reports and recommendations of the Department Chairs and Section Chiefs at its next scheduled meeting following the Credentials Committee meeting. The MEC may, at its discretion, designate one or more of its members to conduct an interview with the. The MEC shall defer action on the application or prepare a written report with recommendations as required by Section 1.6-3.

Medical Executive Committee Actions can include:

(a) Deferral: Action by the Medical Executive Committee (MEC) to defer the application for further consideration must, except for good cause, be followed up within 45 days with its report and recommendations. The Medical Staff President shall promptly send the applicant special notice, through the Medical Staff Office, of an action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the applicant and the time frame for response. Failure, to respond in a satisfactory manner by that date without good cause is deemed a voluntary withdrawal of the application.

(b) Favorable Recommendation: An MEC recommendation that is favorable to the applicant in all respects is forwarded to the Board together with all supporting documentation. "All supporting documentation," means an executive summary of the application form and its accompanying information, the reports, and recommendations of the Department Chairs and Section Chiefs, Credentials Committee, and MEC

(c) Adverse Recommendation: An adverse MEC recommendation is forwarded to the CEO who shall inform the applicant by special notice as provided in Section 1.2 of the Fair Hearing Plan and the applicant is then entitled, upon proper and timely request, to the procedural rights provided in said Plan. For purposes of this section, "adverse recommendation" by the MEC is as defined in Section 1.1 of the Fair Hearing Plan.

1.6-8 Board of Trustees Action

As part of any of its actions outlined below, the Board may, at its discretion, conduct an interview with the applicant or designate one or more individuals to do so on its behalf. If the Board determines that it requires further information, it may defer action for not more than 45 days except for good cause and shall notify the applicant and the President of the Staff in writing of the deferral and the grounds. If the applicant is to provide additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him/her must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response to respond in a satisfactory manner by that date without good cause is deemed a voluntary withdrawal of the application.

(a) On Favorable Recommendation: If the Board's action is favorable to the applicant, it is effective as the final decision.

The Board may adopt or reject, in whole or in part, a favorable MEC recommendation or refer the recommendation back to the MEC for further consideration stating the reasons and setting a time limit within which a subsequent recommendation must be returned to the Board.

If after complying with the requirements of Section 1.6-8(e) below, the Board's action is adverse to the applicant in any respect, the CEO shall inform the applicant by special notice as provided in Section 1.2 of the Fair Hearing Plan. The applicant is then entitled to the procedural rights provided in said Plan upon proper and timely request.

(b) In the circumstance that the MEC does not provide its recommendation within the time frame defined in Section 1.6-4 of this Manual or within any reasonable extension of that time frame resulting from deferral of a recommendation in order to obtain additional data/explanation or a specific release/authorization, or from implementation of the Fair Hearing Plan, or from any other good cause, the following procedure shall be followed:

The Board may take action on its own initiative, employing the same type of information usually considered by the Staff authorities, after notifying the MEC of its intent and allowing a reasonable period of time for response. Favorable action by the Board is effective as the final decision. If the Board's action is adverse in any respect, the CEO shall inform the applicant by special notice as provided in Section 1.2 of the Fair Hearing Plan, and the applicant is then entitled to the procedural rights provided in said Plan upon proper and timely request.

(c) After Procedural Rights: In the case of an adverse MEC recommendation, the Board of Trustees takes final action in the matter as provided in the Fair Hearing Plan.

(d) Adverse Board of Trustees Action Defined: For the purposes of this "adverse action" by the Board is defined in Section 1.1 of the Fair Hearing Plan.

(e) Conflict Resolution: Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, the matter shall be submitted to a joint advisory council for review and report before the Board makes its decision. The council will be composed of three members from the Medical Staff who are appointed by the President of the Staff and three members from the Board who are appointed by the Chair of the Board.

1.6-9 Notice of Final Decision

(a) Notice of the final decision is given through the CEO and goes to the applicant by special notice as well as to the Medical Staff President, the MEC, and the applicable Department Chairs and Section Chiefs.

(b) A decision and notice to appoint includes: (1) the Staff category to which the applicant is appointed; (2) the Department and Section, if applicable, to which assigned; (3) the clinical privileges he that may be exercised; and (4) any special conditions attached to the appointment.

The initial staff appointment is for not greater than two years from the Board of Trustees approval date. The first year of the appointment is provisional in nature. (Bylaws Section 3.6)

1.7 Reapplication After Adverse Credentials Decision

An applicant or Staff member who has received a final adverse decision or has voluntarily resigned or voluntarily withdrawn an application for staff appointment, staff category, Department or Section assignment, or clinical privileges is not eligible to reapply for the same for a period of one (1) year from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Exceptions to this time limit may be outlined in the Medical Staff Bylaws and Related Manuals or determined by the Credentials Committee in light of exceptional circumstances.

Any such reapplication is processed in accordance with the procedures set forth in Section 1.6 of this Credentialing Procedures Manual. The applicant or Staff member must also submit sufficient additional information to demonstrate that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed. No applicant or Staff member may submit, or have in process at any given time, more than one application for initial appointment, reappointment, Staff category, a particular Department or Section assignment, or identical clinical privileges.

PART TWO: PROVISIONAL REVIEW PERIOD

Amended 03/11/2009

2.1 Requirements for Successful Conclusion

2.1-1 Review and Observation Required/Practitioner's Obligation

The requirement for, duration of, and status of the practitioner in the provisional period are set forth in Section 3.7 of the Medical Staff Bylaws. As required in that section, each Department shall establish the review requirements for concluding the provisional period in the Department subject to approval by the Credentials Committee, the Medical Executive Committee, and the Board. It is the obligation of the practitioner to arrange for the required numbers and types of cases to be reviewed/observed by the designated proctors prior to the time frames set forth in Sections 2.1-2 and 2.1-3 below. The Medical Staff Office shall prepare the results of the provisional review process for consideration by the appropriate Department Chair.

2.1-2 Request to Conclude/Extend the Period

On or before 90 days prior to the end of the practitioner's first year of appointment to the Staff or significant modification of clinical privileges, the Medical Staff Office shall notify the staff member of the date on which that year will end. No later than sixty (60) days prior to that date, the practitioner must forward to the Medical Staff Office a request to either initiate the evaluation process to conclude all or any part of the provisional period or a request for an extension as provided in Section 2.2.

Failure of a practitioner to act to conclude or extend the provisional period without good cause may be deemed a voluntary relinquishment of Staff appointment and clinical privileges.

2.1-3 Action Required

The Medical Staff Office forwards the practitioner's request to conclude or extend the period, along with the results of the practitioner’s reviews/observations to the Chair of each Department in which the practitioner was granted the initial or modified privileges. The evaluation process set forth in Section 1.6-5 through 1.6-8 of this Credentialing Procedures Manual shall be followed.

2.2 Extension

A Staff member whose caseload at the Hospital was inadequate to satisfy the requirements of the provisional period with respect to all or part of the clinical privileges granted may request an extension of the period for the particular privileges involved. This request must include a statement describing his/her caseload and the circumstances of his/her practice that he expects will enable him/her to meet the requirements if an extension is granted. Members who anticipate that their clinical volume at the hospital will always be limited may request an extension of the provisional period through the conclusion of their initial staff appointment. These members will then be considered for reappointment using the criteria for low volume practitioners as outlined in Section 3.

An extension request must be submitted within the time frames provided in Section 2.1-2 above and is processed as provided in Section 2.1-3 above. Any extension granted must be for a defined period of time not to exceed one additional year. Only one extension is permissible.

2.3 Procedural Rights

Whenever a provisional period, including any period of extension, concludes with an adverse recommendation or action or whenever an extension is denied, the CEO shall provide the practitioner with special notice as provided in Section 1.2 of the Fair Hearing Plan. The staff member shall be entitled to the procedural rights provided in the Plan upon proper and timely request. For purposes of concluding the provisional period, an "adverse recommendation" by the MEC or an "adverse action" by the Board is as defined in Section 1.1 of the Fair Hearing Plan.

PART THREE: REAPPOINTMENT PROCEDURES

3.1 Information Collection and Verification

3.1-1 Information from Staff Member

On or before 120 days prior to the date of expiration of a Medical Staff member's appointment, the Medical Staff Office shall notify him/her/her of the date of expiration and forward an application for reappointment. At least ninety (90) days prior to the expiration date, the member shall return the application for reappointment including: (a) complete information and all documents necessary to make the file current for the items listed in Section 1.3 of this Manual, including current license and DEA and State controlled substances registration, professional liability insurance coverage and claims history, other institutional affiliations and status thereat, Board certification status, disciplinary actions pending/completed; (b) continuing medical education and

other training external to the Hospital during the preceding period; (c) specific request for additions to or deletions from the clinical privileges presently held, with any basis for the changes, and; (d) requests for changes in Staff category or Department or Section assignments. The Staff member must sign the reappointment application and in so doing, accepts the same conditions as stated in Section 1.6 in connection with the initial application. When the Staff member's level of clinical activity at this Hospital is not sufficient to permit an informed judgment regarding current competence to exercise the clinical privileges requested, the Staff member shall have the burden of providing evidence of clinical competence.

If the Staff member has not returned his/her completed application for reappointment by the ninetieth (90th) day prior to the expiration date, the Medical Staff Office shall send a special notice via certified mail that the application has not been received and requesting urgent submission.

Failure to provide the completed reappointment application with all of the requested information in sufficient time for processing prior to the expiration of the current term is deemed a voluntary resignation and results in automatic termination of the appointment at the expiration of the current term. A practitioner whose appointment is so terminated is not entitled to the procedural rights provided in the Fair Hearing Plan.

The Medical Staff Office verifies the information provided on the reappointment application, and notifies the Staff member of any information inadequacies or verification problems. The notice must indicate the nature of the additional information the Staff member is to provide and the time frame for response (10 days). A second notice will be sent via certified mail if the staff member does not respond within 20 days. This notice must indicate the time frame in which the staff member is required to respond. Failure to respond in a satisfactory manner by that date without good cause is deemed a voluntary withdrawal of the application.

3.1-2 Information from Internal Sources

The Medical Staff 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 under Section 3.1-1 above shall form the basis for recommendations and action. These shall include, without limitation:

(a) Patterns of care and utilization as demonstrated in the findings of 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;

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(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. If this documentation is not received and the physician applicant otherwise fulfills the criteria for reappointment, the applicant will be notified that a two-year reappointment may be granted with the condition that, within the next twelve months, he/she must submit documentation of a total of 60 AMA Category I CME credits during that three year period. Failure to submit the required documentation by the end of the twelve-month conditional period will Result in an automatic suspension of clinical privileges that will remain in effect until the CME documentation is received. Section 7.3-5 then applies.

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. If this documentation is not received and the applicant otherwise fulfills the criteria for reappointment, the applicant will be notified that a two-year reappointment may be granted with the condition that, within the next twelve months, he/she must submit documentation of adequate CME/CEU to meet the averaged licensure requirement for that three-year interval. Failure to submit the required documentation by the end of the twelve-month conditional period will result in an automatic suspension of clinical privileges that will remain in effect until the CME documentation is received. Section 7.3-5 then applies..

(c) Level/amount of clinical activity (patient care contacts) at the Hospital. For applicants for reappointment in fields doing surgical or other invasive procedures, the number and types of 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 for reappointment in nonsurgical fields, the number and types of medical conditions managed and the procedures performed by the applicant as the responsible practitioner. All applicants will have clinical judgment and technical skills assessed;

(d) Sanctions imposed or pending and other problems;

(e) Attendance at required Medical Staff, Department, Section, and Committee meetings;

(f) Participation as a 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) For applicants with limited activity at this hospital, a written recommendation from a practitioner in the same professional discipline as the staff member, when available, and who has firsthand knowledge of the applicant. This recommendation refers, as appropriate, to relevant training and/or experience, current competence, fulfillment of obligations as a member of the medical staff, and any effects on the privileges to be recommended.

(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 Staff member's status and privileges at this Hospital, including the Staff member's activities at other hospitals and medical practice outside the Hospital.

3.1-3 Verification of Information

The Medical Staff 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

(e) Other hospital affiliations

In addition, the National Practitioner Databank will be queried.

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 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. Any dissenting views from the majority position at any point in the process must be documented in a minority report which states the reason for the differing view, the information on which it is based, and the alternative recommendations, if any. Any minority report must be transmitted with the majority report.

3.3 Time Periods for Processing

Transmittal of the notice to a Staff member and the member's response with updated information is to be carried out in accordance with Section 3.1-1 of this Manual. Thereafter and except for good cause, all persons and groups required to act must complete such action so that all reappointment reports and recommendations are acted on by the Board prior to the expiration date of Staff membership.

The time periods specified are to guide the acting parties in accomplishing their tasks. If delay without good cause occurs at any step in the processing and is attributable to a Medical Staff or Hospital authority, the next higher authority may immediately proceed to consider the reappointment application and all of the supporting information or may be directed by the President of the Medical Staff on behalf of the Medical Executive Committee or by the CEO on behalf of the Board to so proceed.

In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements or denying the community access to needed medical services, the CEO shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the CEO shall consult with the Chair of the applicable department and the President of the Medical Staff. The temporary clinical privileges shall be only for a period not to exceed 120 days.

In the event the applicant for reappointment is the subject of an investigation or 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.

If the delay is attributable to the practitioner's failure to provide information required by Section 3.1-1, the Staff appointment terminates on the expiration date as provided in Section 3.1-1.

3.4 Department and Section Evaluation

Each Chair of each Department and Chief of each Section in which the Staff member requests or has exercised privileges shall review the reappointment application, its supporting information and pertinent aspects of the Staff member's file, and evaluate the information for continuing satisfaction of the qualifications for Staff appointment, the category of assignment and the privileges requested. If a Chair or Chief requires further information, he/she shall notify the Staff member in writing of the information required. If the Staff member is to provide the additional information, the notice must be a special notice and must include a request for the specific information required and the time frame for response. Failure to respond in a satisfactory manner by the time specified without good cause is deemed a voluntary relinquishment of membership and all clinical privileges.

Each applicable Chair and Chief forwards to the Credentials Committee a written recommendation, including a statement as to whether he/she has observed or been informed of any conduct, which indicates significant present or potential physical, behavioral, or substance abuse problems affecting the practitioner's ability to perform professional and Medical Staff duties appropriately. The report provides recommendations for, and any special limitations on, reappointment or non-reappointment, Staff category, Department and Section assignment, and clinical privileges. Included in any Chair or Chief's report must be any actions or information that was not previously transmitted for inclusion in the Staff member's credentials file concerning his/her clinical performance, fulfillment of Medical Staff affiliation or category obligations, or satisfaction of any other qualifications for appointment or the clinical privileges granted.

3.5 Credentials Committee Evaluation

The Credentials Committee shall review and evaluate the reappointment application and its supporting information, other pertinent aspects of the Staff member's file, the Chairs' and Chiefs' reports and all other relevant information available to it. If the Credentials Committee requires further information, it shall notify the Staff member in writing of the information required. If the Staff member is to provide the additional information, the notice must be a special notice and must include a request for the specific information required and the time frame for response. Failure to respond in a satisfactory manner by the time specified without good cause is deemed a voluntary relinquishment of membership and all clinical privileges.

The Credentials Committee shall prepare a written report with recommendations for, and any special limitations on, reappointment or non-reappointment, Staff category, Department and Section assignment, and requested clinical privileges. The Credentials Committee's report is transmitted with the Chairs' and Chiefs' reports and supporting documentation, as required, to the Medical Executive Committee.

3.6 Final Processing and Board Action

Final processing of reappointments follows the procedure set forth in Sections 1.6-7, 1.6-8, and 1.6-9. For purposes of reappointment, an "adverse recommendation" by the MEC or an "adverse action" by the Board is as defined in Section 1.1 in the Fair Hearing Plan.

PART FOUR: DELINEATING AND MODIFYING 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 forms, all Staff members holding privileges in the Department must, as appropriate to the circumstances, complete the new forms, request and be processed for privileges added, or comply with the fact that a privilege was deleted.

4.2 Procedure for Delineating Privileges

4.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant or Staff member.

Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappraisals.

4.2-2 Processing Requests

All requests for clinical privileges are processed according to the procedures outlined in this Manual, as applicable.

4.3 Modification of Appointment Status or Clinical Privileges

A Staff member may, at any time, request modification of his/her Staff category, Department or Section assignment, or clinical privileges by submitting a written request to the Board of Trustees as specified below. A modification request is processed according to the procedures outlined in Section 1.6 of this Manual and must contain all pertinent information supportive of the request.

Requests to change Staff category will be routed through the Department Chair (and Section Chief, if applicable) who will determine the impact of the change on the hospital's inpatient care capabilities and the departmental call coverage responsibilities. The Chair evaluation will specifically comment on whether the staff category change will have a positive, negative, or neutral effect on these areas. A report should include a reasonable basis for the recommendation including alternate suggestions if negative impact is indicated. The request, evaluation, and recommendation will thereafter be routed to the Credentials Committee, Medical Executive Committee, and Board of Trustees for consideration and action. If the staff category change is denied, the requesting staff member may be entitled to a Fair Hearing based on current Bylaws.

A Staff member who chooses to no longer exercise or to 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, as applicable, the restriction or limitation. This notice shall be routed as in section 1.6 and then included in the member's credentials file.

Amended 06/11/07

A staff member who plans to make a significant change in his/her practice situation shall send advanced written notice (at least 30 days) to the appropriate Department Chair indicating the particulars of the change. Examples include 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. Significant changes in status, such as resignation, retirement, or change in military status, will be routed as in section 1.6.

PART FIVE: SPECIAL PRIVILEGING PROCEDURES

5.1 Procedure for Granting Temporary Privileges

5.1-1 Circumstances

Temporary privileges may be granted under the following circumstances per Bylaws section 5.7.

(a) To fulfill an important patient care, treatment, or service – or –

(b) When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and Board of Trustees.

Each of these circumstances has individual credentialing requirements.

Amended 03/11/2009

5.1-2 Privileging Requirements to Fulfill an Important Patient Care Need

Temporary privileges for the fulfillment of important patient care, treatment, and service needs will be granted upon verification of the following:

(a) Completed application, including request for specific privileges;

(b) Current state licensure;

(c) Current DEA and Rhode Island Controlled Substance Registration (if applicable);

(d) Adequate professional liability insurance coverage (if applicable);

(e) Positive reference from medical staff authority at the practitioner's current hospital affiliation(s);

f) Query of the National Practitioner Databank (NPDB);

g) Written concurrence of the Department Chairman; and

h) Written concurrence of the Medical Staff President

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 Navy Form Appendix N, which has been signed by the Commanding Officer, or designee, Naval Health Clinic New England will satisfy the above licensure and reference requirements. Such Appendix N shall contain documentation that the following have been verified at the primary source by the Department of Defense:

(1) Completion of professional school, degree, internships, residency, and fellowships;

(2) Expiration dates of current state licensures and certifications;

(3) Expiration date of specialty board certifications and/or recertifications;

(4) Contingency training in basic life support, advanced cardiac life support, advanced trauma life support, and pediatric and/or neonatal advanced life support as applicable;

(5) A list of current Naval Health Clinic New England staff privileges; and

(6) A list of requested clinical privileges at Newport Hospital if different from (5) above; and

(7) A statement indicating whether the practitioner applying for temporary privileges is under investigation.

5.1-3 Privileging Requirements for a Completed Application Pending Formal Approval

Temporary privileges for new applicants may be granted when the application is complete and raises no concerns while awaiting review and approval by the Medical Executive Committee and Board of Trustees.

The completed application fulfills all requirements for consideration of temporary privileges if justifiable circumstances warrant.

5.1-4 Granting Temporary Privileges

All temporary privileges are granted by the Chief Executive Officer (CEO), or authorized designee, based on the recommendations of the Medical Staff President and appropriate Department Chair and Section Chief.

The practitioner shall complete a Newport Hospital-approved orientation that includes a tour of the Hospital and familiarization with relevant Hospital policies and procedures prior to exercising the clinical privileges.

5.1-5 Duration of Temporary Privileges

The temporary clinical privileges will be granted for a limited, designated period of time that will not exceed 120 days.

5.2 Procedure for Granting Disaster Privileges

5.2-1 Circumstances

The Chief Executive Officer, or his/her designee, may grant disaster privileges when the hospital's emergency management plan has been activated and the organization is unable to handle the immediate patient needs.

Amended 06/14/2006

5.2-2 Processing

Practitioners, staff affiliates, and allied health professionals who do not possess staff privileges at Newport Hospital may be granted disaster privileges under the circumstances outlined in Section 5.2-1 of this manual. The Chief Executive Officer or, if unavailable, the administrator-on-call, has the authority to grant disaster privileges. Practitioners, staff affiliates, and allied health professionals who seek disaster privileges shall possess either an active license issued by the state of Rhode Island or an active or military license to practice in another state. The Chief Executive Officer, or his/her designee, is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis at his/her or her discretion. Disaster privileges may be granted upon the presentation of one of the following:

Amended 06/14/2006

(a) A current picture hospital identification card; that clearly identifies/designates professional status;
(b) A current active license to practice or a primary source verification of a current license to practice;
(c) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC) Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organizations or groups;
(d) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances; such authority having been granted by a federal, state, or municipal entity; or
(e) Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer practitioner's clinical ability to perform during a disaster.

The Medical Staff Office shall complete primary source verification of licensure as soon as the immediate situation is under control and within 72 hours of granting disaster privileges. Circumstances precluding completion within 72 hours will be documented in the file. Continuation of privileges beyond 72 hours will be based on feedback related to performance. During prolonged disaster efforts (anticipated to last weeks), the Temporary privileging process will be initiated as above.

Amended 06/14/2006

5.2-3 Conditions

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:

(a) Reflect the individual's training and specialty;
(a) Be granted for the duration of the disaster only;
(b) Automatically terminate at the end of the needed services or at the discretion of the chief executive officer or his/her designee;
(c) May be immediately terminated by the chief executive officer or his/her designee in the event any information is received which suggests that the individual is not capable of rendering services; and
(d) Termination of disaster privileges, regardless of cause, shall not entitle the practitioner to a hearing or review as outlined in the Fair Hearing Plan.

5.3 Procedure for Granting Telemedicine Privileges

5.3-1 Definition

Telemedicine is the exchange of information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services.

This section applies to those practitioners not appointed to the medical staff who will have total or shared responsibility for the care of a patient at the hospital through the use of a telemedicine link. "Total or shared responsibility" is evidenced by the practitioner having the authority to effect medical orders and direct a patient's care, treatment or services.

This section does not pertain to practitioners who are providing either official or preliminary readings of images, tracings, or specimens through a telecommunications link. Those practitioners will be credentialed as outlined in section 5.4.

Amended 03/11/2009

5.3-2 Privileging Process

The options for privileging these practitioners follow. The option selected will depend on the service rendered and arrangements available with the distant site.

(a) Credential and grant privileges by the same processes as in Parts One through Four of this manual although these practitioners are not appointed as members of the medical staff.
(b) Credential and grant privileges as in 5.3-2 (a) but utilize the credentialing information from the practitioner's primary hospital, provided that the hospital is accredited by The Joint Commission.

(c) Credential and grant privileges to the practitioner based on the credentialing information and privileging decision from the practitioner's primary hospital if the following conditions are met:

(1) The primary hospital is accredited by The Joint Commission;

(2) The practitioner has clinical privileges at the primary hospital to perform the same service or procedure being requested at the hospital; and

(3) The hospital reviews the practitioner's performance of the privileges being requested and provides information resulting from that review to the primary hospital.

This option will be reviewed and updated coincident with the practitioner's appointment at the primary hospital.

Practitioners privileged under these circumstances will not be considered members of the medical staff.

5.4 Procedure for Granting Teleradiology and Similar Privileges

5.4-1 Definition

This section applies to practitioners whose only role at the hospital is to provide either official or preliminary readings of images, tracings, or specimens through a telecommunications link.

Amended 03/11/2009

5.4-2 Privileging Process

The options for privileging these practitioners follow. The option selected will depend on the contract with and The Joint Commission accreditation status of the distant site.

(a) When the hospital contracts for patient care, treatment, and services rendered outside of the hospital but under the control of a Joint Commission accredited organization, the hospital an proceed with one of the following mechanisms:

(1) Specify in the contract that the contracting entity will ensure that all services provided by the contracted individuals who are Licensed Independent Practitioners (LIPs) will be within the scope of his/her privileges at the primary site. (The medical staff and Board have determined that this mechanism is the preferred mechanism when available.) ; or

(2) Verify that all contracted individuals who are LIPs and who will be providing patient care, treatment, or services have appropriate privileges, for example by obtaining and retaining a copy of the list of privileges.

Updates of the LIPs' status will be specified in the contract and will occur with any change in status or not less than annually.

(b) When the hospital contracts for patient care, treatment, and services rendered outside of the hospital but under the control of a non-Joint Commission accredited organization, the hospital will privilege all LIPs providing services by the standard medical staff credentialing and privileging process.

Practitioners privileged under these circumstances will not be considered members of the medical staff.

PART SIX: LEAVE OF ABSENCE

6.1 Voluntary Leave of Absence

A Staff member may, for good cause, obtain a voluntary leave of absence by giving written notice to the Chair of the Department in which he has his/her principal affiliation for review, recommendation, and transmittal to the Credentials Committee and Medical Executive Committee (MEC). The notice must state the approximate period of time of the leave, which may not exceed two years, except for military service. During the period of the leave, the Staff member's clinical privileges, prerogatives, and responsibilities are suspended. The MEC makes a report and recommendation on the leave to the Board for its final action.

6.2 Termination of Voluntary Leave of Absence

The Staff member must, at least 30 days prior to the termination of the leave, or at any earlier time, request reinstatement by sending a written notice to the Department Chair. The Staff member must submit a written summary of relevant activities during the leave and provide evidence of current licensure, DEA, and State controlled substances registration, and professional liability insurance coverage. The procedures in Section 1.6 of this Manual, as applicable, are followed in evaluating and acting on the reinstatement request.

6.3 Medical Leave of Absence

A practitioner who develops an illness, disability or condition which significantly impacts on the ability to meet hospital practice obligations or safely perform the approved clinical privileges shall promptly notify the chair of the department. When ready to return to practice, the practitioner shall notify the Department Chair and provide appropriate evidence the ability of resume the practice of previously granted clinical privileges. Return to unlimited practice following a temporary change in the ability to practice due to a medical condition may require fulfillment of the conditions outlined in Section 3.1-6 of the Medical Staff Bylaws.

PART SEVEN: INVESTIGATIVE PROCESS

7.1 Investigative Process Other Than Precautionary or Automatic Suspension

7.1-1 Initiation, Requests and Notices

The criteria for initiating an intervention or investigation other than a collegial intervention, initial review, and precautionary or automatic suspension are contained in Section 6.1 of the Medical Staff Bylaws. All requests for further investigation and intervention must be in writing, submitted to the Medical Executive Committee (MEC), and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Medical Staff President shall promptly notify the CEO in writing of all requests, and shall notify the practitioner involved by special notice of any such request.

7.1-2 Investigation

After deliberation, the MEC shall either act on the request or direct that an investigation be undertaken. The MEC may conduct such investigation itself or may assign this task to a Medical Staff general or Department/Section officer, a Department, a Section, a standing or ad hoc committee, or any other Medical Staff component. This investigative process is not a "hearing" as that term is used in the Fair Hearing Plan. It may include a conference with the practitioner involved and with the individual or group making the request and with other individuals who may have knowledge of the events involved. If the investigation is accomplished by a group or individual other than the MEC, that group or individual must forward a written report of the investigation to the MEC as soon as is practicable after the assignment to investigate has been made. The MEC may at any time within its discretion, and shall at the request of the Board terminate the investigative process and proceed with action as provided below.

The MEC or other investigating group or individual shall have available the full resources of the Medical Staff and the Hospital as well as the authority to use outside consultants as deemed necessary. As part of the investigation, the MEC or other investigating group or individual may require the practitioner involved to procure an impartial physical or behavioral health evaluation within a specified time and pursuant to the guidelines set forth below. Failure to do so, without good cause, shall result in immediate suspension of his/her Medical Staff appointment and all clinical privileges until the evaluation is obtained, the results are reported to the MEC or other investigating group or individual, and the Board takes final action. The practitioner(s) who will conduct the examination shall be named by the MEC or other investigating group or individual. Fees for an evaluation shall be paid by the Hospital.

7.1-3 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigative process, if any, but in any event within six (6) months after receipt of the request for further investigation or intervention, the MEC shall act upon such request. Its action may include, without limitation, recommending:

(a) Rejection of the request for further investigation or intervention;
(b) A verbal warning or formal letter of reprimand;
(c) Additional education and/or training;
(d) Individual medical/psychiatric treatment;

(e) A probationary period of prescribed duration with retrospective review of cases and/or other review of professional behavior but without special requirements of prior or concurrent consultation or direct supervision;

(f) Suspension of appointment prerogatives that do not affect clinical privileges;

(g) An individually imposed requirement of prior or concurrent consultation or direct supervision;

(h) Limitation of the right to admit patients where such limitation is not related to the adoption or implementation of an administrative or Medical Staff policy within the Hospital as a whole or within one or more specific Departments, Sections or special units;

(i) Reduction, suspension or revocation of all or any part of the clinical privileges granted;

(j) Suspension or revocation of Staff appointment.

7.1-4 Procedural Rights

An MEC recommendation pursuant to Section 7.1-3 (h), (i) or (j), or any combination thereof, is deemed adverse and entitles the practitioner, upon timely and proper request, to the procedural rights contained in the Fair Hearing Plan.

7.1-5 Other Action

(a) An MEC recommendation pursuant to Section 7.1-3 (a), (b), (c), (d), (e), (f), or (g) or any combination thereof, is transmitted to the Board together with all supporting documentation. Thereafter, the procedure in Section 1.6-8 of this Manual is applicable.

(b) If, in the Board's determination, the MEC fails to act in timely fashion in processing and recommending action on a request for further investigation or intervention, the procedures in Section 1.6-8 of this Manual will be followed.

7.2 Precautionary Suspension

7.2-1 Criteria for Imposing

The criteria for imposing a precautionary suspension and the parties authorized to do so are designated in Section 6.4 of the Medical Staff Bylaws.

7.2-2 Medical Executive Committee Action

Amended
12/14/2005
06/14/2006

Whenever reasonably possible, the MEC will convene within seven (7) business days after a precautionary suspension is imposed to review and consider the action taken. The MEC may recommend either modification or continuation of the precautionary suspension, or termination of the precautionary suspension. The recommendation to terminate the precautionary suspension is transmitted immediately to the Board together with all supporting documentation. The terms of the precautionary suspension as originally imposed remain in effect pending a final decision by the Board. In either circumstance, the investigative process delineated in Section 7.1 continues.

7.3 Automatic Suspension

7.3-1 Circumstances

The circumstances under which an automatic suspension may be imposed and the scope of said suspension are defined in Section 6.5 of the Medical Staff Bylaws.

7.3-2 Medical Executive Committee Deliberation

Amended 12/14/2005

As soon as practicable (a) after a practitioner's license is suspended, restricted or placed on probation, or (b) after his/her DEA or State controlled substances number is revoked, restricted, suspended or made probationary, the MEC shall convene to review and consider the facts under which such action was taken. The MEC may then recommend such further action as is appropriate to the facts disclosed in the investigation, including limitation of prerogatives. Thereafter, the procedure in Section 7.1-4 or 71-5, as applicable, is followed, but only with respect to any additional action recommended by the MEC or by the Board.

7.3-3 Medical Records Completion

Amended 11/08/06

The medical record completion process is delineated in the Rules and Regulations, Section B.

If a practitioner appears on the delinquency list three times within a six-month cycle, his/her privileges will be administratively suspended until all incomplete records are completed.

If a practitioner appears on the delinquency list a fourth, and any subsequent, time within a six-month cycle, his/her privileges will be administratively suspended until all incomplete records are completed AND the practitioner will be referred to the MEC for collegial intervention.

Amended 11/08/06

Notification of suspension letters will be signed by the Medical Staff President. Suspension means that the practitioner will not be allowed to admit, treat or consult nor will he/she be permitted to see patients in the Emergency Department or anywhere within the hospital or remote medical offices. To provide the practitioner time to arrange for coverage or reschedule patients, the actual suspension of privileges will not occur until 1:00 a.m. on the second Monday following the date the notification of suspension letter is mailed.

Amended 12/14/2005

Health Information Services will send notification of suspension of privileges, including the beginning and ending dates and times of the suspension period, to:

- President and Chief Executive Officer
- Medical Staff Department Chair
- Vice President of Medical Affairs
- Medical Staff President
- Patient Registration Department
- Operating Room
- Ambulatory Surgery
- All Nursing Units
- Emergency Department
- Administrative Coordinators
- Cardiopulmonary Services

Practitioner and Medical Executive Committee Responsibility

Amended 12/14/2005 11/08/06

The suspended practitioner must abide by the terms of the suspension.

The suspended practitioner may request a special meeting of the Medical Executive Committee to consider factors that might warrant waiving the suspension period. The meeting will be held within one week of receipt of the letter indicating the third, any subsequent, delinquency and the practitioner will be required to attend this meeting to explain the circumstances to be considered. If the suspension period is not waived, suspension of privileges will begin at 1:00 a.m. on the Monday following the special Medical Executive Committee meeting.

The Health Information Services Director must be notified in writing of any decision made by the Medical Executive Committee that necessitates an action on the part of Health Information Services.

Deficiencies and Credentialing: The inability of a practitioner to complete his/her health care records within 30 days of patient discharge is taken into consideration in the credentialing process at the time of reappointment to the Medical Staff.

Enforcement of Policy

Amended 12/14/2005

The responsibility for enforcing this policy rests with the Medical Executive Committee and the Medical Staff Department(s) involved.

If a practitioner's privileges are suspended, and he/she requests an admission, calls to schedule surgery (either elective, emergency or ambulatory) or requests to see a patient in the Emergency Department, he/she will be advised by the Patient Registration, Operating Room or Emergency Services personnel that he/she is on suspension and the request will be denied.

7.3-4 Professional Liability Insurance

A practitioner whose Staff appointment and clinical privileges are suspended for failure to maintain the required minimal level of insurance may request reinstatement of appointment and appropriate privileges by sending a written notice to the Chair of the Department in which he held appointment and to the CEO along with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the previous insurance being canceled or not renewed and any limitations on the new policy. The Staff member must submit a written summary of relevant activities during the period of suspension if the Department Chair or Section Chief, Credentials Committee, or the MEC or Board so requests. The procedures in Sections 1.6 and 1.7, as applicable, are followed.

Amended 12/14/2005

7.3-5 CME Conditional Reappointment

A practitioner who fails to submit documentation of adequate CME to satisfy a condition of reappointment will have his/her Staff appointment and clinical privileges automatically suspended with an effective date one year from the conditional reappointment. Notification of the possibility of pending action will be routed as in Sections 1.6-6, to 1.6-9 during the month leading up to the possible suspension.

The automatic suspension will remain in effect until the required documentation is received. Once the CME documentation is submitted to the Medical Staff Office and fully meets the CME requirement, the Medical Staff Office will route written notification to the pertinent Department Chair, Medical Staff President, and CEO or designee. With their concurrence, the staff member will be reinstated and forwarded written verification of the reinstatement.

If the suspension continues through the conclusion of the current staff appointment, the member will not be eligible for reappointment at that time. Further applications will be considered per Section 1.7.

PART EIGHT: STAFF AFFILIATES

8.1 Definition

Staff Affiliate is an individual who is

- Qualified by formal training, prior and continuing experience and current competence in a health care discipline which the Board has approved to practice in the Hospital, and
- Licensed by the State, and
- Permitted by the Hospital to provide services independently in the Hospital, i.e., without the direction or immediate supervision of a physician.

Staff Affiliates are not considered members of the Medical Staff. (Definition #18)

8.2 Current Categories

Current policy of the Board of Trustees permits the following types of Staff Affiliates to provide services in the Hospital:

(1) Podiatrists

(2) Psychologists

(3) Nurse Practitioners

(4) Nurse Midwives

8.3 Qualifications

A statement of qualifications for each category of Staff Affiliates who are not Hospital employees shall be developed by the Credentials Committee, 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), and from other representatives of the Medical Staff, management, and the Hospital's other professional staff; and

(b) Require that the individual Staff Affiliate 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) List as requirements at least the following:

(1) Appropriate professional education and training or experience for the privileges or services being requested, preferably including experience in an acute care setting such as a hospital.

(2) Current ability to provide services at an acceptable level of quality and efficiency as evidenced by experience and outcomes.

(3) Demonstrated ability to work with others in a cooperative, professional manner.

(4) High moral character and adherence to generally recognized standards of professional ethics and to all State regulations and conditions applicable to his/her practice.

(5) Freedom from or adequate control of any significant physical or behavioral impairment, including alcohol or substance abuse.

(6) Ability to communicate in the English language, both verbally and in writing, to effectively perform the clinical and administrative functions outlined in this section.

(7) Adequate professional liability insurance coverage.

8.4 Prerogatives

The prerogatives of Staff Affiliates are to:

(a) Exercise such clinical privileges as are specifically granted and consistent with any limitations stated in the Medical Staff Bylaws and related manuals, the policies governing the Affiliate's practice in the Hospital, and any other applicable Medical Staff or Hospital policies.

(b) Serve on committees when so appointed and with vote if so specified by the appointing authority.

(c) Attend, when invited, clinical, scientific, and educational meetings of the Staff or a Department or Section when appropriate to his/her discipline.

(d) Exercise such other prerogatives as the Medical Executive Committee with the approval of the Board may accord Staff Affiliates in general or a specific category of Staff affiliates.

8.5 Obligations

Each Staff Affiliate must:

(a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate at facilities such as the Hospital.

(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 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 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 those portions of patients' medical records documenting services provided and any other required records in a timely fashion as required in the Medical Staff Rules and Regulations.

(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.

8.6 Terms and Conditions of Affiliation

Each Staff Affiliate shall be individually assigned to the Department and Section, if applicable, appropriate to his/her professional training and is subject to an initial provisional review period, formal reappraisal, and disciplinary procedures as determined for his/her category.

A Staff Affiliate's exercise of clinical privileges 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 Staff Affiliates 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.

8.7 Scope of Privileges and Service Description

The scope of clinical privileges available to any group of Staff Affiliates shall be developed by the Credentials Committee with input from the appropriate Department Chairs and Section Chiefs, as applicable, and representatives of management. The scope is subject to the approval of the Board.

Notwithstanding the apparent scope of practice permitted to any group of Staff Affiliates 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.

8.8 Procedures for Credentialing

The principles governing and procedures for processing individual applications from Staff Affiliates, for reviewing performance during the provisional review period, for periodic reappraisal, and for disciplinary action shall be the same as those set forth in Articles Three, Six and Seven of the Medical Staff Bylaws, in Parts One, Two, Three, and Seven of this Manual, and in the Fair Hearing Plan.

PART NINE: ALLIED HEALTH PROFESSIONALS

Amended 03/11/2009

9.1 Definition

An Allied Health Professional (AHP) is an individual who is qualified by academic and/or clinical training and by prior and continuing experience 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. Allied Health Professionals are not considered members of the Medical Staff.

9.2 Current Categories

Current policy of the Board of Trustees permits the following types of AHPs to provide 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.

(4) Cardiac Nurse – AHP

9.3 Qualifications

A statement of qualifications for each category of AHP shall be developed by the Credentials Committee, 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 AHP, and from other representatives of the Medical Staff, management, and the Hospital's other professional staff; and

(b) Require that the individual AHP 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) List as requirements at least the following:

(1) Appropriate professional education and training or experience for the privileges or services being requested, preferably including experience in an acute care setting such as a hospital.

(2) Current ability to provide services at an acceptable level of quality and efficiency as evidenced by experience and outcomes.

(3) Demonstrated ability to work with others in a cooperative, professional manner.

(4) High moral character and adherence to generally recognized standards of professional ethics and to all State regulations and conditions applicable to his/her practice.

(5) Freedom from or adequate control of any significant physical or behavioral impairment, including alcohol or substance abuse

(6) Ability to communicate in the English language, both verbally and in writing, to effectively perform the clinical and administrative functions outlined in this section.

(7) Adequate professional liability insurance coverage.

9.4 Prerogatives

The prerogatives of AHPs are to:

(a) Provide such specifically designated patient care services as are granted under the degree of supervision or direction of a Medical Staff member as specified in the grant of services. The conditions will be consistent with any limitations stated in the Medical Staff Bylaws and related manuals, the policies governing the AHPs' practice in the Hospital, and any other applicable Medical Staff or Hospital policies.

(b) Serve on committees when so appointed and with vote if so specified by the appointing authority.

(c) Attend, when invited, clinical, scientific, and educational meetings of the Staff or a Department or Section when appropriate to his/her discipline.

(d) Exercise such other prerogatives as the Medical Executive Committee with the approval of the Board may accord AHPs in general or a specific category of AHPs.

9.5 Obligations

Each AHP must:

(a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate at facilities such as the Hospital.

(b) Participate when requested in quality review and risk management program activities and in such other functions as may be required from time to time.

(c) Attend clinical and educational meetings of the Staff and of the Department or Section and any other clinical units with which affiliated.

(d) 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 President.

(e) 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.

(f) 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.

(g) 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.

9.6 Terms and Conditions of Affiliation

Each Allied Health Professional (AHP) shall be individually assigned to the Department and Section, if applicable, appropriate to his/her professional training and is subject to an initial provisional review, formal reappraisal, and disciplinary procedures as determined for his/her category.

An AHP'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 AHP's 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.

Continued affiliation as an Allied Health 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 staff affiliation. Termination of staff affiliation for this reason does not entitle the AHP to due process under the Fair Hearing Plan.

9.7 Scope of Privileges and Service Description

Notwithstanding the apparent scope of practice permitted to any group of AHP under Rhode Island law or licensure, the scope of privileges and guidelines described below 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.

Written guidelines for the performance of specified services by each category of AHP shall be developed by the Credentials Committee (or subcommittee thereof) with input, as appropriate, from the physician supervisor of the AHP and from representatives of the Medical Staff, management and the Hospital's other professional staffs and subject to the approval of the Board. For each category of AHP, such guidelines must include at least:

(1) Specification of categories of patients that may be seen.

(2) A description of the services to be provided and procedures to be performed, including any special equipment, procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the medical record.

(3) Definition of the degree of assistance that may be provided to a practitioner in the care of patients on Hospital premises and any limitations thereon, including the degree of practitioner supervision required.

9.8 Procedures for Credentialing

The principles governing and procedures for processing individual applications Allied Health Professionals, for reviewing performance during the provisional review period, for periodic reappraisal, and for disciplinary action shall be the same as those set forth in Articles Three, Six and Seven of the Medical Staff Bylaws, in Parts One, Two, Three and Seven of this Manual, and in the Fair Hearing Plan.

PART TEN: REFERRING ASSOCIATE

Amended 03/11/2009

10.1 Referring Associate

Individuals in this category desire Hospital association without clinical privileges nor active operational involvement. Practitioners in this category may not admit patients, shall not have clinical privileges, and are not members of the medical staff.

Amended 04/08/2009

10.2 Qualifications for Referring Associate

A Referring Associate

(a) Must fulfill the general requirements of the corresponding provider type with clinical privileges as delineated in the Medical Staff Bylaws and related manuals.

The following additional provider types are eligible to participate in this category:
Chiropractors

(b) Should have an expectation of referring patients to the Hospital for services.

10.3 Prerogatives of Referring Associate

A Referring Associate:

(a) May refer patients and participate in continuing medical education.

(b) Is eligible to visit referred patients, have access to clinical information systems, and review and receive copies of related medical records and correspondence regarding patients referred for an episode of care.

(c) Is not eligible to hold office in the Staff organization nor to vote.

(d) Is not required to attend Department or General Medical Staff Meetings.

10.4 Obligations of Referring Associate

A Referring Associate is expected to:

(a) Provide sufficient information regarding patients referred to the Hospital for services to enable continuity of care and record keeping.

(b) Inform the Credentials Coordinator of any changes of any personal or professional information that was provided on the staff application, including but not limited to certifications, licensure, office or home addresses, and/or contact numbers.

10.5 Procedures for Credentialing

Since referring staff members do not exercise clinical privileges in the Hospital, the credentialing and privileging process is streamlined to items pertinent to their status and include the following:

- Education
- Training
- State License(s)
- Board Certification (information requested but certification not required)
- Affiliations for Past 10 Years
- Professional Reference (one)
- Proof of Identity
- NPI
- National Practitioner Data Bank Query

Pertinent information above will undergo primary source verification, except for Board Certification, as it is not mandatory for category membership.

The specific application requirements and processing follow those pertaining to the corresponding provider type as delineated elsewhere in the Bylaws and related manuals with the following exceptions:

(a) Referring Associates will be assigned to their own administrative department rather than specialty specific medical staff department since hospital association is administrative in nature and devoid of clinical implications. Oversight will be provided by the Vice President of Medical Affairs in conjunction with the medical staff hierarchy.

(b) Participation in specialty specific or other medical staff functions will be considered on request.

(c) Initial appointments will not engender a provisional period as Referring Associates are not granted clinical privileges or incur operational involvement.

10.6 Recourse

Members of this category do not have recourse through the Fair Hearing Plan. Association is solely at the discretion of the Hospital.

PARTELEVEN: AMENDMENT

11.1 Amendment

This Credentialing Procedures Manual may be amended or repealed, in whole or in part, by a resolution of the Medical Executive Committee (MEC) recommended to and adopted by the Board.

11.2 Responsibilities and Authority

The procedures outlined in Article Fourteen of the Medical Staff Bylaws shall be followed in the adoption and amendment of this Credentialing Procedures Manual, provided that the MEC may act for the Staff within the requirements of said Article Fourteen.

PART TWELVE: ADOPTION

12.1 Medical Staff

This Credentialing Procedures Manual was adopted and recommended to the Board of Trustees by the Medical Executive Committee on May 09, 202005.

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/s/ Arnold Sarazen, MD
President of the Medical Staff
Newport Hospital

12.2 Board of Trustees

This Credentialing Procedures Manual was approved and adopted by resolution of the Board of Trustees on June 8, 202005, after considering the Medical Executive Committee's recommendations.

_____
/s/ Suzette Schochet
Secretary, Board of Trustees
Newport Hospital

_____
/s/ Arthur J. Sampson
President & Chief Executive Officer
Newport Hospital